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## ORIGINAL DEPARTMENT.

### COMMUNICATIONS.

#### PNEUMONIA—NO. IV.

BY HIRAM CORSON, M.D.,  
Of Conshohocken, Pa.  
(Continued from page 263.)

Since my articles have appeared in the REPORTER, I have received from some of your readers letters thanking me for what I have written, and presenting some cases of their own, which are well worth publishing, as evidence of the widespread fear to deplete a patient in a recent acute attack of inflammation of the lung; as evidence too of the good results produced by depletion by drawing blood, in such cases, and as evidence of the mortality following the treatment recommended by some teachers in our medical colleges, who rely on the aconite, veratrum, digitalis, carb. ammonia, and stimulant and stuffing treatment.

Dr. W. B. T., of Paris, Texas, writes: "I have just read with great pleasure your several articles on pneumonia, and I am glad to find you laboring to restore 'the lost art,' in the treatment of that disease. At the last meeting of the 'North Texas Medical Association' I read an essay (by appointment) on the above disease. I said that blood-letting was the remedy par excellence in sthenic pneumonia, and in all cases where I felt certain of the proper time, and in many cases where I felt uncertain, I am now satisfied that the patient might have been better off in other hands. Had I remembered one sentence in Watson's Practice, I might always have known the proper time, viz: 'never bleed for the extravasated products of inflammation.' The period of engorgement is of vari-

able duration, and that exact time is any time between the reaction from the chill to the beginning of the second stage. Sometimes the congestion involves so great an amount of lung tissue that great weakness and prostration are manifested from the beginning; in which condition nothing is so effectual as a free bleeding.

"The association fought me hard on the blood-letting, in which fight the fact was developed that several old practitioners, and of some notoriety, had never bled or blistered a patient laboring under any disease, or condition, in all their professional career.

"To my mind, aconite and veratrum were questionable rivals of the lancet from the beginning; the former always a dangerous dose and of very little account in anything, and the latter greatly overrated in everything. I am glad that you have taken up your pen again, as one page from an experienced observer is worth more to a young practitioner, if he will heed it, than volumes of the labored, far-fetched fume and froth of the latter-day saints, whose practice might be termed a sort of sickly sentimentality, that amounts to less than nothing."

It will be found, by those who will take pains to observe, that many of those who oppose blood-letting are like the old doctors spoken of above, who had never bled a patient in any disease.

Dr. J. H. B., of Cook county, Illinois, writes: "I hope that I may read more of your remarks on pneumonia, as I consider them of much value to myself, being founded on long experience. I can well remember two particular cases of pneumonia that occurred in my ward while acting as interne in the City Hospital, Boston. One, a robust young man, on expectant treatment, with

diet, etc. etc., which was followed persistently. The result was unsatisfactory—extremely so. The other case—in brief—a slender boy of twelve or thirteen years of age, with whom the ordinary routine treatment was given. At midnight I was called, with the information that he had suddenly grown worse. I found him with respiration very much increased, pulse very rapid and somewhat strong, face suffused, and somewhat delirious. Not being a bleeder, I did not bleed, yet I suppose a kind of instinct prompted me to do the next best thing, and so I cupped him well on the back and side of the chest. On my visit next morning, as I was passing down the ward, he cocked his head up and grinned all over at me, and when I went to his bedside, he asked me, with a smile on his face, 'Doctor, can't I go to work to-morrow.' He felt well, and soon fully recovered. That boy twelve hours before was in a dying condition, and without depletion he would have died. I have waited to hear somebody speak intelligently in regard to bleeding, which, so far as I knew, seemed to have fallen into obscurity. I believe in the faith of our fathers, and would consider it a favor if you would continue to give us your experience. Our fathers knew something (although this micro physiological generation of physicians is very wise), and I shall be glad to have your experience on other subjects, as well as on that of pneumonia."

W. C. W., M.D., writes, from Sandy Hook, Conn.: "I cannot refrain from thanking you personally for your firm stand in reference to the treatment of pneumonia by blood-letting. Since your first letter was published, I have treated three bad cases after your plan, with perfect success in every case. One was an old man of seventy-eight years. I had to work hard to get them to consent, but I finally bled him freely and saved his life, I am assured. Pneumonia in this section is very fatal, with the cold weather, and it really made me sick at heart to be called to a case; but now I feel that I have a weapon equal to the foe. I am under many, many obligations to you, and only hope you will have a reprint sent all over the land."

Dr. J. C. S., writing from Three Springs, Pa., says: "I have been very much interested and instructed by your papers on pneumonia in the MEDICAL AND SURGICAL REPORTER. Pneumonia is considered very fatal here, especially among the aged. We never bled our patients. I heard Dr. Gross, four years ago—while attending lectures at the 'Jeff'—recommend blood-letting in pneumonia, and heard Dr. Da Costa condemn it. As the latter was supposed to be authority

'on practice,' I chose to follow him. My preceptor used blisters and tartar emetic, and I have seen good results and some failures from their use. I saw, with a neighbor physician, just before your first article appeared, a stout, hearty man go down in five days, in spite of aconite, blisters, carb. ammonia, poultices, and all the stimulants that could be got into him. I then thought I would try the lancet—although I never had any instruction in its use—and thus far have bled six patients in pneumonia. In two of them there was complete cessation of all untoward symptoms following venesection. The other four passed on to the second stage, but are convalescent; two of the four were old ladies, one 65 years, and of slight frame. I think your suggestion of bleeding late saved one of those old ladies. It was the third or fourth day of her illness when I found her insensible, gasping for breath, absence of any respiratory sound over entire right lung, left lung partly engorged, bronchial râles, and all signs of complete engorgement. It was a case of which I would ordinarily have said, 'it will die in six hours.' But I had her supported in bed, and then bled her freely. She became relieved immediately (all the cases have experienced decided relief), and slept soundly that night, and the next day I found her much better; has done finely since. I am not writing to give you an account of my limited practice, but to thank you for your service to me and to my patients; also, if you have not made up your mind what part to consider next, I would suggest to you to take up *the treatment of pneumonia in children*. I hope my suggestion is not out of place, as I think you will have great trouble to convince the profession of the propriety of bleeding children, although willing to try it on adults."

Dr. D. W. K., of Allegheny City, writes: "Your article on pneumonia and its treatment meets with my hearty endorsement, and I congratulate you upon having written so clearly and intelligently upon so grave a disease."

Dr. J. G. C., of Kittanning, writes: "I have just finished your last article on 'Blood-letting in Pneumonia,' in the MEDICAL AND SURGICAL REPORTER. I am a practitioner of fifteen years' standing, and do not bleed except in a few cases. I am satisfied I do not bleed often enough. I have seen the great benefit derived from it. I write you this short letter to thank you, in the name of the Armstrong County Medical Society, for the firm stand you have taken on this subject, and also as to the natural delivery of the placenta and on natural delivery."

Dr. R. L. M., of Spring Valley, Minnesota, says, on a postal card: "Your articles on Pneumonia, in the REPORTER, were read by me with great interest. I believe in your words. I am sure that I have lost patients because I did not treat them as you direct, but followed the rule we were taught. \* \* \* Give us other articles."

A very prominent physician of this State writes to me: "I have read with great pleasure your articles on Pneumonia, in the REPORTER. The only point that I would hesitate about would be the ice-bag. I am attending now a young man with pneumonia of lower half of left lung. On Sabbath I bled him till he roused out of his stupor and sleep, and put a blister on his side—a slow one—and gave him purgatives and expectorants. Yesterday he was doing well: pulse 116; temp. 105°; delirium subsiding; sputa free and bloody. I have not had a large experience of this disease, but have never lost a case. My neighbor loses cases frequently, of very stout people; he neither bleeds nor blisters. I say, bleed, blister, and give purgatives and expectorants immediately."

Dr. Amos Seip, of Easton, Pa., says: "Though past the midnight hour, I cannot retire without expressing to you my hearty thanks for your timely article in the REPORTER, on the treatment of pneumonia. I think it is high time that the much-abused instrument, the lancet, shall be again carried in the pocket and used in the treatment of acute inflammatory diseases. The idea that diseases of the present day will not bear depletion as well as they did thirty or forty years ago, is preposterous. It is a mere whim; a blind following of the miserable, French, expectant plan, that so many of our modern teachers have adopted in the treatment of pneumonia, etc. I have been in practice more than thirty-two years, yet have never given up the use of blood-letting in acute diseases, especially those of the chest, brain, etc. It is absurd, if not criminal, for a physician to allow an attack of pneumonia to go through its three stages, if called early. No, I agree heartily with you; not only is blood-letting well borne in acute diseases, but also that, with the adjuvants, it is the only rational treatment. It is sad to take up the public prints and read of this and that noted man, 'died of pneumonia.' But is it any wonder, when such pernicious doctrines are promulgated by those whose office it is to teach young men—hundreds of whom leave our colleges not only untaught in the use of the lancet, but prejudiced against it by their teachers? No! a thousand times No! The day must come, is coming,

when they will see the unfortunate results of this modern heresy. Now, a word on my own experience; for, after all, one severe attack of disease in a physician's own person is worth all the theory in the world, so far as practice is concerned. Some nine or ten years ago I suffered from a severe attack of pneumonia. I had been exposed, in rough, November weather; the symptoms gradually increased in intensity; there was high fever; respiration above 30; pulse 120; sputa tough and rust colored, with severe pain; in short, all the symptoms of an exaggerated attack. I could compare the pain felt at each respiratory effort to nothing else than that which would be produced by a jagged knife thrust into the side. I stood it for about eight hours, then sent for my friend, Dr. Traill Green, who, unfortunately, was not at home. Before daylight I said to my wife, 'this is simply death itself, if relief be not soon had; get my lancet, the bandage, etc.; when I cut the vein let the blood run till I show signs of faintness.' As the vein in the left arm did not develop well, I was compelled to use the left hand and bleed from the right arm. Never shall I forget that night. With the instrument in my left hand, I let fly; the blood flew; took sixteen ounces before the desired effect was produced; then fell over on the bed. I breathed freer immediately; a grateful perspiration bedewed the surface; all the symptoms were moderated, and next morning, when Dr. Green arrived, finding me much better, he advised to continue the medicine I was using, and left, promising to call again. I indulged too much, that afternoon, in conversation with medical friends; at any rate, by night all my pain, and fever, and difficult respiration returned. Dr. Green came in and bled me another pint, and again I felt easier; and that bleeding, with the ordinary treatment of thirty years ago, 'broke up,' as Dr. Green said, one of the most formidable attacks of pneumonia that either of us had ever seen. The peculiar *weakness* that you speak of I well remember. Never shall I forget it. One such an experience is worth all the weak, timid, do-nothing theories and practice in the world. What, let me ask you, would have been the result if we had let it alone and turned our attention to the liver and kidneys? It would require no prophet to tell the result. The modern notion that aconite, veratria, digitalis, etc.—and yes, the poultice—will supersede the lancet is sheer nonsense. I would be ashamed to look a family in the face, if I were to lose a father or son, ill with pneumonia, and had failed to use it."

There are a number more postals and letters lying before me, which have been sent to me to express approbation, by the writers, of the views I have expressed; but they must be passed by for the present.

These extracts confirm the truthfulness of the statements made by me in reference to the value of the lancet, and testify, like voices from the grave, of those dead prematurely from erroneous treatment. As I write, my eye falls on a postal received but yesterday, from which allow me to quote—so appropriately does its confession come in here: "Your articles on pneumonia are just excellent in theory, and in practice, doubtless, would be found as you claim. Many cases of the disease die in the ——— hospital; some of sthenic forms, which, I doubt not, might have been saved (?) I am going to possess a lancet before many days, and use it when opportunity presents." He had served in a Philadelphia hospital; a young man of fine abilities, a profound student, sent from a medical college ignorant of even the *art* of bleeding, then serving for a year or more in a hospital, and there seeing men die of pneumonia, while his "Chief" was denouncing the only remedy which could have saved them. How sad! And yet, how much more sad is the reflection that this very year there have been hundreds sent from the colleges ignorant as he was of the value of venesection and the mode of using the lancet, and ready to take on themselves the treatment of this disease by means recommended by theoretical teachers, who are searching for something new which may hereafter be associated with their names. With your permission I shall continue this subject.

In closing this paper, I feel that I ought to apologize to the authors of the above letters, for having—through fear of being charged with a desire to magnify myself—shorn them of the enthusiasm, the thankful and grateful feelings under which they were written, and which testify so strongly of the sense of duty which impelled them to write on this subject. Here, too, I may properly refer to an error which slipped into my first paper, namely: Speaking of Bayard Taylor dying of pneumonia, when I knew very well that he died in Germany, of another disease. I intended to name Thomas Buchanan Read; the substitution of the one for the other was an accident. For many years I had admired the writings of these two highly gifted men, so dear to the people of eastern Pennsylvania, and in my mind always intimately associated. Was it strange, then, that, in my hurried way of writing, I should have put the name of him—

"Whose latest verse  
Was a garland on his hearse."

in the place of his whose genius gave to us, as part of its creations, the "Autumn Scene" and the "Spirits of the Waterfall?"

#### THE HYGIENE OF OLD AGE, WITH SPECIAL REFERENCE TO PROSTATIC HYPERTROPHY AND SECONDARY DISEASE OF THE BLADDER.

BY REUBEN A. VANCE, M.D.,  
Of Cincinnati, Ohio.

Read before the Cincinnati Academy of Medicine.

The subject chosen as a text for my remarks this evening is one that can be treated in part only on such an occasion as this. I have, therefore, determined to limit my remarks to the indications and effects of prostatic hypertrophy, and the steps to be taken for its relief. Curtailed as is the subject by these restrictions, it is, nevertheless, too voluminous for thorough treatment in the time at my disposal. Therefore, if I but outline to you a few of the more important facts bearing upon senile enlargement of the prostate body, and review such of the morbid anatomical conditions of the urinary apparatus as I deem of interest in this connection, and then allude to the method of relief I consider of vital importance, I shall accomplish all I think it advisable to attempt.

The normal prostate, let me premise, is shaped like a chestnut, and, longitudinally, is an inch and a half from base to apex, one and three-quarters transversely near the base, and seven-eighths of an inch in thickness at the latter point, while in weight it is from four and a half to five drachms. Now, while marked excess in either measurement or weight denotes hypertrophy, alteration in form is a far more certain criterion by which to judge. Nevertheless, there are many cases in which bladder-disease develops as a consequence of senile enlargement of the prostate, in which physical exploration fails to yield any evidence of increased bulk or modified form on the part of the prostate body.

Sir Henry Thompson, who, conjointly with Dr. Messer, dissected the prostates in about 200 subjects over 55, found that about one in three exhibited some enlargement of that organ, but only one of these out of seven had had symptoms of the complaint. According to Thompson, the period of life between 55 and 65 is that during which the affection most commonly begins to be developed. He has never met with an instance of hypertrophy of the prostate at so early a pe-



riod as 50 years of age, while on the other hand he says it appears rarely to commence after 70, and is exceptional after 80 or 85. He thinks that the man who has escaped enlargement of the prostate at 65 will never be troubled with it. In senile hypertrophy there is an augmentation of the muscular and connective tissues of the prostate, with little, if any, increase of the glandular element. There is increase of volume, weight, and density, with modification of form. The enlargement may be general or partial.

Common as is prostatic hypertrophy, and well defined as are the symptoms accompanying its advanced stages, there are few affections more obscure in their early manifestations. A few months ago a well-known gentleman of this city stopped me on the street with the remark that he had been intending to call and see me for some time; that his kidneys were troubling him, and he wanted something that would relieve the distress from which he was suffering. A question or two speedily revealed the nature of the case. For months he had been compelled to get up two or three times of a night to relieve his bladder, and he was now conscious that each act of micturition, although prolonged and difficult, was of little avail so far as a free evacuation of the urine was concerned. The urine was clear; it never had contained blood; but there was, at the time of my first interview with this patient, an almost constant call to urinate, and each act freed but a small quantity of urine. No amount of explanation sufficed to make him appreciate the true nature of his case. He had an all-sufficient explanation for the phenomena troubling him so greatly; this was, "irritability of the bladder," alternating with "congestion of the kidneys." If the nature of senile enlargement of the prostate was spoken of, and the fact that his age—he was in his 49th year—predisposed him to it, and, furthermore, if his attention was called to the fact that the frequency of micturition from which he suffered was due to retention and repletion—a morbid degree of retention of urine, owing to his inability to evacuate more than a small quantity, thus leaving a certain amount of residual urine in the bladder, which increased week by week—he was sure that the contrary was the case, for he knew that he was passing more water than usual. According to his view of the matter—one supported by the authority of his family physician—his kidneys were congested enough to cause hyper-secretion of urine, and his bladder was so irritable that it would retain but a few tablespoonsful at a time. To try to make this patient believe that his bladder was

water-logged, so to speak, that he was carrying about with him from a pint to two quarts of water, each act of micturition but discharging a gill or so of urine, the organ never emptying itself completely, but on the contrary gradually falling into a diseased state from the continuance of the unnatural conditions under which it was placed, was mere waste of time. The last act in the preliminary stage of this case occurred within ten days of the interview referred to. He called and announced that something must be done for his relief, for he was in a deplorable plight; that his bladder, "which had been so irritable as to retain but a small amount of urine at a time, for months," had now utterly failed him; that for a week water had been dribbling from him at night, while sleeping, while for the last forty-eight hours it ran away from him, drop by drop, sleeping or waking. Upon passing a catheter, twenty-five ounces of urine were withdrawn; finding the bladder distended still, the catheter was removed, and the patient informed of the necessity for prolonged treatment.

This patient's experience is typical of that of many who suffer from this complaint. In the very beginning the individual may be conscious of nothing but an unusual degree of reluctance—if I may so express it—on the part of the bladder to part with its contents. The patient experiences a call to urinate; he places himself in position to respond to nature's demand, but so soon as he does, the power of the bladder to empty itself seems temporarily impaired. The experienced surgeon sees in this condition the influence of an abnormal prostate; far different is it with the patient. Without he, by chance, secures competent professional advice, the patient never knows the true nature of his disease, or even that it is a disease, until the condition of his bladder forces him to seek surgical aid. A want of power to promptly empty the bladder, in a man between fifty and sixty years of age, almost invariably indicates prostatic enlargement. If, in addition to this delay in emptying the bladder, there is either an increase in the frequency of the calls to urinate, or a diminution in the quantity of urine passed, this condition is denoted. Frequency of micturition, a diminution in the quantity of urine voided, a failure or marked impairment of the individual's ability to empty the bladder promptly and satisfactorily, indicate commencing obstruction from senile enlargement of the prostate. In a word, when a man beyond forty-five years of age experiences an increase in the frequency of his calls to empty the bladder, or has his attention drawn to that

organ by a delay in emptying it, or an inability to accelerate the flow of urine after it starts, he should suspect prostatic hypertrophy.

The anatomical condition accompanying prostatic hypertrophy, preventing complete evacuation of the bladder, is very simple and quite devoid of all danger, provided proper hygienic measures are adopted from the first. In the beginning but a minute amount of urine may remain in the bladder. It is not improbable that, in many cases, accident initiates this condition. In order to empty the bladder, time is necessary. Circumstances which prevent the patient giving the requisite attention to this function may be the means of developing secondary disease of the bladder. A patient with commencing hypertrophy of the prostate—a lawyer—was engaged in an exciting trial, and the day he addressed the jury he neglected the proper evacuation of his bladder; that night the urine dribbled away while he was asleep; the next morning, upon passing a catheter, I discharged a quart and a half of urine and found the bladder completely atonied. If individuals suffering from senile enlargement of the prostate could be made to appreciate the fact that the mere hypertrophy of that organ is a matter of secondary consideration, while the condition of the bladder is of vital moment, fewer sad cases of secondary vesical disease would be encountered.

I have said little, as yet, of that condition in which these cases all result: distention of the bladder with overflow of urine. Every surgeon knows but too well how commonly these cases are mistaken for the very opposite state; how the sufferer will argue that he cannot have anything but incontinence, for the self-evident reason that he is constantly passing water. Yet, in truth, his condition is but the final stage of the cases to which I have been alluding. Day by day, and little by little, there is a slow accumulation of urine in the gradually distending bladder. At first the patient, finding it tedious to stand in the water-closet and completely empty his bladder, discharges only enough to relieve himself for the time. The ounce or two of urine thus left by negligence may not be voluntarily voided at the next act; in this way the seeds of urinary decomposition and bladder disease are planted. In one case the quantity of urine increases from day to day, until, finally, the bladder becomes full and its walls atonied; in another case the retained urine undergoes decomposition, and inflammation of the lining membrane of the bladder is induced; in both, the resulting disease can be traced to the neg-

lect of complete evacuation of the bladder. Strange to say, if the practitioner is careful to save and measure the urine daily passed by such a patient, the amount voided in the twenty-four hours will be found fully equal to the ordinary discharge of a healthy individual in the same interval of time. It does seem as if the local irritation had some effect in increasing the quantity of urine secreted; this is especially true as regards the night as distinguished from the daytime. Such a patient will be compelled to get out of bed and use the night-vessel from five to thirty times between bedtime and morning. While the amount voided on each occasion may not be large, yet upon taking the whole quantity discharged in the twenty-four hours and comparing it with that usually passed daily, in health, there will be no material difference. This partially explains the incredulity of certain patients when informed of the nature of their disease. Any intelligent man can understand his surgeon when the latter tells him that his bladder is irritable and impatient when but a minute amount of urine is present; that his frequent calls to micturate and trouble in emptying the bladder arise from vesical irritability and urinary incontinence. Quite different is it when an endeavor is made to explain the complex conditions arising from prostatic obstruction, muscular atony, and vesical catarrh. The patient shrinks from an instrumental examination, and is loth to have a catheter introduced, even for diagnostic purposes.

Yet, upon the proper employment of this last instrument depends the prevention of secondary disease of the vesical cavity in individuals suffering from prostatic enlargement, and the relief of those patients who have been so unfortunate as to have atony of the muscular walls, or catarrh of the lining membrane of the bladder ensue as a consequence of prior disease of the prostate body. Just so soon as an individual of the male sex, who has passed his forty-fifth year, finds himself compelled to micturate more frequently than usual—especially at night, and under circumstances excluding obstructive disease of the urethra—surgical advice should be taken, and a catheter employed. If a catheter is then passed—and it should be used immediately after the patient has voided all the urine he can voluntarily discharge—and a quantity of residual urine withdrawn, the surgeon has an unmistakable guide both as to diagnosis and treatment. That process of urinary retention has been inaugurated, which, if not relieved, will certainly result in either atony of the vesical walls and indefinite

distensibility, or in contraction of the bladder and partial hypertrophy of the muscular layers. The details of the measures which should be adopted in connection with the use of the catheter in these cases I need not dwell upon; suffice it to say, that a few weeks' judicious employment of that instrument will relieve even the most unpromising cases, and permanently cure the majority of patients with commencing bladder disease. I shall also dismiss, with a word, the danger attendant upon the injudicious employment of the catheter. Sir Benjamin C. Brodie long since pointed out a peculiar class of patients in whom the complete evacuation of the urine by the catheter, at one time, was apt to be followed by serious results. This danger can always be obviated by removing but a part of the residual urine at any one time: in order to do this, the catheter should be introduced and the bladder but partially emptied twice a day, for three days. The point upon which I desire to lay special stress, is the necessity for immediate resort to the catheter so soon as the early symptoms of prostatic obstruction declare themselves, and its use sufficiently often thereafter to empty the bladder at least once daily, and thus prevent urinary accumulation and vesical disease. By adopting this course the great number of cases of bladder disease in old men may be reduced to the minimum, and the profession afford most efficient service in advancing the hygiene of old age, with special reference to those secondary affections of the vesical cavity which have their origin in prostatic hypertrophy.

## TWO CASES OF PULMONARY SYPHILIS.

BY CARL SEILER, M.D.

Read before the Philadelphia Laryngological Society.

So little is known about pulmonary syphilis or syphilitic phthisis that I feel prompted to put on record two cases of the affection which came under my notice during my recent sojourn in Jacksonville, Florida.

CASE I.—Mr. M., æt. 26, had been sent south to spend the winter, being, as was supposed, afflicted with tuberculosis. When he consulted me he complained of a harassing cough, with copious expectoration, which was tenacious and of a yellowish-greenish color, frequently tinged with blood; great dyspnea, hoarseness amounting almost to aphonia, and difficult and painful deglutition, the pain during the act of swallowing being most severely felt in the left ear. He was very much emaciated and feeble, but had no night sweats. He stated that the trouble com-

menced about three months previous, with cough, loss of appetite and flesh; that he had taken various remedies, but without relief, and that he had finally been advised to go south. He had been in Florida for several weeks, but felt discouraged, as he had not only not improved, but that his throat had become worse. On physical examination of the patient's chest, which was well developed, I found the usual signs of infiltration, but most marked in the middle and lower lobe of the right lung, while the apices of both lungs were almost free from any disease.

On inspection of the throat, I found the following condition of the parts: The soft palate was hyperæmic and somewhat relaxed, the uvula slightly elongated, and at the free edge of the velum I noticed two sharply-defined bands of inflammation, extending from the anterior pillars to within a short distance of the root of the uvula. The posterior pillars were intensely red and showed two small elongated ulcers, one on either pillar, symmetrical both in shape and position. The pharynx was dry, red, and its follicles enlarged. With the laryngoscope the epiglottis was seen to be very much thickened and of a horseshoe shape, with an ulcer extending almost over the entire free margin of the organ. On account of this swelling the interior of the larynx was obscured, but I could see enough to detect an ulcer on the left arytenoid cartilage, extending into the inter-arytenoid commissure.

The ulcerations in the throat might have been explained by supposing them to be due to tubercles, yet the symmetrical disposition of the ulcers on the posterior pillars, the sharply-defined lines of inflammation on the free margin of the velum palati, and the absence of the ashy-gray discoloration of the mucous membrane, which we always observe in phthisis, made me suspicious that the case might be one of laryngeal syphilis, and that perhaps the lung disease might be due to the same cause. I therefore questioned the patient as to a previous specific history, but could not obtain any satisfactory answer. The patient stated that he had had an attack of gonorrhœa four years previously, but had had no skin eruption or swelling of the glands; his throat had been sore on several occasions, and he suffered from rheumatic pains in his limbs, especially at night. He stoutly denied ever having had a chancre. In spite of this rather unsatisfactory history, I decided to put the patient on anti-syphilitic treatment. I accordingly gave him ten grains of iodide of potassium three times a day, together with cod-liver oil, and as much other nourishing food as he could swallow. I also or-

dered inunctions of cod-liver oil over the chest and back, and had his arms and legs washed with whisky night and morning. The ulcers I touched with iodized glycerine, of the following composition: iodine, grs. 5; iodide of potassium, grs. 30; glycerine, fl. ℥j; washing off the thick coating of pus first with a solution of bichloride of mercury, 1½ grs. in glycerine and water, each two ounces, thrown into the larynx by means of an atomizer.

Under this treatment the patient rapidly improved; his dyspnoea diminished, deglutition became less painful and difficult, he gained strength and flesh, and was able to walk a considerable distance without undue fatigue, two weeks after the treatment had been commenced. The ulcerations in the larynx gradually healed, and, although considerable loss of tissue resulted, yet, after four weeks, he was able to swallow without discomfort. A physical examination of his lungs, about this time, showed still some dullness over the middle and lower lobe of the right lung, while the left lung and the apex of the right one seemed entirely free from disease. When last seen the patient was progressing as well as could be desired, and considered himself almost well.

CASE II.—Isaac S., a negro laborer, aged 30, consulted me about a persistent and at times violent cough, shortness of breath, and loss of strength and flesh. He also complained of soreness of the throat and great dryness of the fauces. He stated that he had first noticed any trouble about three months before, and attributed it to a cold, contracted while on a spree, on election night. His expectoration was tough and of a yellow color, sometimes streaked with blood, especially in the mornings.

On physical examination I found his chest expansion to be normal, and ordinary percussion revealed nothing abnormal; but on percussing the lungs as a whole, I noticed a decided difference in the pitch between the two sides of the chest, the right side being higher in pitch than the left. On auscultation, a few moist râles were heard in the middle and lower lobes of the right lung. On examination of the throat I found the velum and pillars to be intensely red, the pharynx dry and shiny, and the papillæ on the back of the tongue red and enlarged. With the laryngoscope I noticed the same intense red color in the mucous membrane of the larynx; the epiglottis was normal; the aryepiglottic folds were swollen and red; an ulcer, which seemed rather superficial, was noticed on the right arytenoid cartilage, while the left one was the seat of most

intense inflammation; the vocal cords were slightly reddened and seemed somewhat thickened. On inquiry, the patient admitted that he had had a primary sore three years before, and had since that time suffered from other secondary syphilitic affections, but supposed to have been entirely cured, as he had not suffered from any of them for a year. A careful examination of the other organs failed to reveal any syphilitic affection in them, and I had been induced to suspect syphilis in this case from the appearances of the throat only.

I put this patient on the same treatment as the other one, omitting the inunctions of oil, however, as there was no difficulty of deglutition, and the patient could take enough food internally to build him up. After having taken the iodide of potassium for about a week, he complained of so severe a coryza and of other symptoms of iodism that I found it necessary to substitute daily inunctions of ½ drachm unguentum hydrarg. into the skin of the arms. After this he improved very rapidly, and four weeks later all symptoms of lung as well as of throat affection had disappeared, and he was able to go to work again.

Through a careful study of the above reported cases, as well as of a number of others similar to them, which, from time to time, have come under my notice, I have arrived at certain conclusions in regard to this affection, conclusions which are shared with me by other observers, and especially by Schnitzler ("Die Lungensyphilis," by Dr. John Schnitzler, Vienna, 1880), who reports a number of cases of syphilitic phthisis. Thus I found that syphilis of the lung is far more frequent than is generally supposed; that it usually shows itself in the secondary and tertiary stage of the constitutional affection; that the symptoms, on the whole, are those of pulmonary phthisis, and that even at the post-mortem examination the two morbid processes are difficult to differentiate; that the diagnosis must rely upon the changes in the lung, the previous history of syphilitic infection, and the demonstration of syphilis in other organs, especially in the larynx, which can only be done by means of the laryngoscope; that the prognosis is, on the whole, favorable, and that if the nature of the disease is not recognized early and treated accordingly, it usually runs into phthisis and ends in death; and finally, that the treatment should be anti-syphilitic, energetic, and carefully watched, and that if any lesions exist in the fauces or larynx they should be healed up by local applications. Then often wonderful results are obtained.

1346 Spruce street.



## HOSPITAL REPORTS.

JEFFERSON MEDICAL COLLEGE  
HOSPITAL.

CLINIC OF PROF. S. D. GROSS.

Reported by FRANK WOODBURY, M.D.

**Stricture of Oesophagus, of Syphilitic Origin.**

GENTLEMEN—Our first case to-day is one of stricture of the oesophagus, in a man who was formerly a nurse in this hospital, which you remember as the one in which I succeeded in passing a small bougie into the stomach at our last meeting. There was a want of resistance after passing the contracted part of the tube, which was sufficient evidence that I had gone beyond the stricture. There was also, as you remember, a little blood upon the instrument when it was withdrawn. On the day following the operation he was seized with pain in the limbs; he ached all over. There was also want of appetite, with increasing difficulty in deglutition. He required morphia for the relief of this pain, and we were obliged to support him by the method of rectal alimentation; milk and whisky, in the form of milk punch, with beef juice, were given, as enemata, several times daily. He feels very wretched, and is much opposed to this mode of nutrition, but we are obliged to resort to it, as he cannot swallow food in any form whatever.

The prognosis is poor. I merely brought him before you to show that he is worse than he was, and I will not, at present, pursue the treatment by dilatation. The stricture, from the history of the case, is probably syphilitic in its character, but whether it be so, or epitheliomatous, cannot positively be determined without a post-mortem examination; and the poor fellow has left directions that such an examination shall be made.

**Stricture of the Rectum; Probably Syphilitic.**

This patient (a woman, 27 years of age,) came here yesterday, from Washington City, on account of some trouble in the rectum. She brought a note, addressed to me, from Dr. Marker, Surgeon in Charge of the Columbia Hospital. In this letter the doctor says that Mrs. X. "has been suffering for several years with rectitis and stricture, supposed to be specific. She has used various rectal applications, iodoform, and had the stricture dilated with bougies, etc., though with but little benefit."

The first thing to be done is to make an investigation into the local condition. We may make an examination here with the finger alone, or the finger aided with a speculum. In most cases of stricture of the rectum the seat of the disease is found low down, or just within the verge of the anus; more especially so when it is of a syphilitic character.

Stricture in this situation may be caused by the discharge from a soft chancre or chancroid, or from a syphilitic chancre; the matter, passing from the vagina and vulva along the perineum, coming in contact with the parts, attacks the mucous membrane at the anus, as well as the tube within. In this way you will find rectal stricture not unfrequently caused in the female

sex; but it also may be caused indirectly through a constitutional taint; the specific poison acting upon the system at large and making its local impression in this spot. Whether it is one or the other, in this instance, I cannot say; nor could I positively tell you, even after a careful examination, whether it is due to a syphilitic taint of the system, or to epitheliomatous disease of the bowel.

Epithelial cancer may occur in this situation, as it does in many other parts of the body, without obvious cause. It may appear at the anus and extend into the rectum, or may attack the bowel alone. In the latter case the disease is usually situated about two and a half inches above the anus, within easy reach of the finger.

Oiling my right index finger, and introducing it gently into the anus with a spiral motion, it comes in contact at once with a stricture about two inches above the sphincter. I am now passing through it, the surface of the stricture being around my finger; it is somewhat rough, and the opening is just about large enough to admit the index finger; it seems to be annular or circular in its shape. That is to say, it embraces the entire circumference of the bowel, having a central opening just sufficient to admit the finger. It is a thin stricture, not having much depth to it, about half an inch, apparently. I imagine that I could dilate this with my finger, but I will not do so without further deliberation.

When I say that I would not proceed without full deliberation, I mean to teach you that it would not be safe to dilate this stricture without proper care. Remember that this spot is the seat of purulent discharge, and has, therefore, chronic disease of its vessels; a rupture of this stricture might produce inflammation, which, extending to the peritoneum, would cause fatal inflammation. For this reason you should be very careful how you proceed in these cases. It would be better to wait, and after deciding to operate, incise this diseased mucous membrane by superficial longitudinal incisions, in several places, with the bistoury, before introducing a bougie. An ordinary spermaceti candle makes an excellent dilator; it is a capital bougie. The bleeding from these slight incisions or scarifications is usually insignificant, and can be readily stopped by applications of a piece of lint wet with Monsel's solution diluted with water.

The duck-bill uterine speculum, as it is called, of Sims, offers the best means of examination for rectal exploration; it is worth all the rest put together. Of course, before the examination is made, the proper plan is to empty the bowel with a large warm-water injection.

I wish to impress this point particularly upon your minds, that there is danger in meddling with a stricture without full deliberation and proper preparation of the case; for untimely or improper interference may result in fatal consequences.

The patient reports that her general health and appetite are good, and she considers herself, in all other respects, as in excellent condition.

Now if this disease be due to a taint of the system, as is supposed by Dr. Marker, the proper treatment would be to place her upon iodide of potassium with some salt of mercury—

R. Potassii iodidi, gr. x  
Hydrarg. chlor. corrosiv., gr.  $\frac{1}{10}$ . pro dosa.  
Given in some proper menstruum.

The iodide is to be gradually increased to twenty-five grains given three times a day, if the stomach will bear it.

I am quite sure that even this would not be sufficient to cure the stricture unaided; it would only serve to relieve it to some extent, even with the assistance of the bougie. When the disease reaches this stage, entire relief is out of our power, but it may be held within bounds for a number of years, by attention to the general health and keeping the bowels loose, so that there are several passages a day. If the appetite continues fair, and the general health remain good, life may be prolonged for a number of years beyond what would otherwise be expected in these cases.

#### Paralysis of Forearm Following Injury Involving the Median Nerve.

This young man, twenty years of age, presents himself with some trouble in his left hand. You observe that he has lost power in the thumb and first two fingers, and that they are contracted and somewhat atrophied. He says that eight months ago he received an incised wound with an axe, just below the bend of the elbow, directly in front, where we find a decided cicatrix.

The injury doubtless involved the nervous supply of the thumb and adjoining fingers; the median nerve was probably divided; the ulnar nerve, supplying the little and ring fingers, escaped injury. The hand is cold; the circulation and innervation are both impaired. The wrist can be flexed, but there is some contraction interfering with full extension. He says his forearm feels numb. Comparing his upper extremities, we notice a striking difference between them; the muscles on the right side are developed to a normal degree; the temperature is good; here, in the left side, the muscles are flabby and soft, in consequence of want of due supply of nerve force and deficient amount of blood. The nerve current cannot pass to these muscles, on account of the injury to the main trunk, thus giving rise to fatty degeneration, absorption, and atrophy.

The question of treatment resolves itself into what shall be done to stimulate the nerve and give more blood to the part affected? I take it for granted that no treatment can restore the limb to a natural condition; the nerve has been divided and by this time has degenerated, so that the nervous fluid has been cut off from the outer aspect of the forearm, and also to the parts immediately below the line of the wound. Still, something can be done with a view of re-animating these structures. What I have the most confidence in is the hot and cold douche, daily applied, in some cases several times a day; pouring upon the limb in the first instance, from a little elevation (ten or twelve inches), water as hot as can be borne by the patient, followed by a similar amount of cold water, from a pitcher, flowing in a steady, continuous stream. Having repeated this, he shall take a fringed towel wrung out of cold water and slap the limb from the shoulder down to the hand, until the skin becomes thoroughly

red. This is a powerful stimulant to the peripheral nerves and the capillary circulation. Indeed, I know of nothing, for such cases, as good as this. We may also use in combination veratris ointment—

R. Veratriæ, 3j  
Unguenti, 3vij. M.

Apply with the bare fingers, twice in twenty-four hours, a piece the size of a pea, which should be well rubbed in over the affected muscles.

I place great reliance upon flagellation with a towel, the fringe of which should be at least three and a half inches in length. It is a powerful excitant of reflex action. If I should ever be so unfortunate as to nearly lose a patient under the administration of chloroform, or any other anæsthetic, I should at once turn him upside down so as to make the blood run to the brain, and have him at the same time vigorously slapped with a fringed towel wrung out of cold water, in the manner just described; it is a powerful stimulant to respiration. If you have an asphyxiated child, from the effects of giving chloroform or ether during parturition, the best plan is to spank the infant well with a towel, in this way. Nothing can compare with it for effectiveness, it is better than the galvanic battery.

#### Paronychia, with Remarks upon Diagnosis and Treatment.

This young lady has a felon on the left index finger, involving the distal phalanx. Notice the swelling and discoloration around the nail, and at one point some appearance of pus. This is what we call a felon, paronychia, or whitlow.

This affection is exceedingly painful, especially so when deep seated and when it involves the periosteum. In some cases the inflammation begins in the deeper layer of the skin, and may be comparatively superficial; but in others it commences in the periosteum, and involves all the structures in its progress from the bone to the skin. It frequently arises without any assignable cause; in some it follows slight injuries, such as the prick of a needle; and in other cases it is associated with some disorder of the general system.

The symptoms are familiar to you, from seeing similar cases previously; I need not dwell upon them. The proper treatment is free incision, making the knife grate upon the bone. This will reduce the tension, stop the burrowing of the pus, and yield infinite relief; it will also save the bone from destruction, if made sufficiently early. I laid great stress, the other day, when speaking to you on this subject, upon the importance of laying open a felon down to the bone; otherwise you will not have done your duty, and the bone may suffer necrosis.

Having now laid this freely open, I will order her an elm-bark poultice, containing some lead-water, and give quinine internally. I need not discuss the many new remedies that might be used with more or less advantage; it is not well to experiment with new remedies until we know exactly how much can be done with the old. Out of the vast number of preparations of the pharmacopœia, some fifteen or twenty will answer for almost every purpose for which the phy-

sician needs them; the others are relatively of little use. After all, the old friends are always the best.

#### Dislocation of Finger from a Fall—Reduction.

This man, sixty years of age, fell on going up his cellar stairs, and injured his hand. Notice the difference in the length of the fingers. In looking at the hand in profile, the middle finger looks as if the posterior portion of the second phalanx were thrown up on the dorsal surface of the first phalanx. We will give him a little ether, and reduce the dislocation.

Luxations are very uncommon, both of the phalanges of the fingers and of the toes; but still these dislocations may and do take place. When they occur they may be in two principal directions: upward, in which the distal may rest upon the dorsal surface of the first phalanx; and downward, or the opposite condition. Generally, the dislocation is upward and backward.

Anæsthetics make cowards of us all. No matter how innocuous the agent, there is always some apprehension on the part of the patient that he may not wake up; although the greatest care may be taken, still he will feel that accidents have happened, and they may happen again. We need, therefore, to reassure the patient, and not to refuse him our sympathy.

I have here a pair of forceps, made for this purpose, with which I seize the dislocated phalanx (the instrument being well guarded by a bandage), the assistant making counter-extension by grasping the wrist at the same time that I draw upon the phalanx and extend it, and it slips easily into place. We will now wrap up the joint in lead-water and laudanum. Passive motion should be instituted at the end of six or seven days, to prevent ankylosis.

#### Neurosis of Portion of Temporal Bone, Following Scarlet Fever.

E. C., six years of age. About the beginning of January, 1880, this little girl had scarlet fever, which was quite a severe attack, and was followed by continued depression. In the fourth week she had a large swelling behind the left ear, which opened twice, and has never healed. Last week a spicule of bone was discharged from behind the ear. There had also been a discharge from the ear, her mother says, during the progress of the fever.

Giving ether, I find a piece of dead bone presenting in the sinus, which is apparently a portion of the mastoid process of the temporal bone. This removed with the forceps, the surface of the sinus is scraped so as to put the ulcer in a proper condition for the development of healthy granulations, by which the wound will be healed. The further treatment of the case should be conducted upon general principles.

#### Hydrocephalus—Remarks upon Pathology and Treatment.

This baby, nine months old, shows a remarkable development of its head, it is, moreover, a very large child for its age. The sutures are quite widely open. The mother tells us that the child is fretful and seems sometimes to suffer pain. It has not had any convulsions. The cir-

cumference of the child's head is twenty four inches, two months ago it was twenty-two inches. Notice that the eyes are apparently small in proportion to the size of the head, and that they are in constant motion. This is due to pressure of the fluid contents within the skull upon the optic nerves. The eyes are somewhat inverted, there is a slight convergent squint. The child nurses well, can move all its limbs, urinates freely, and has no trouble with its bowels.

This is a case simply of ordinary hydrocephalus, although it was not noticed until the baby was about two months old. Beyond all question it was congenital, as is almost invariably the case in this disease. The amount of water present is evidently considerable, but, of course, its exact quantity cannot be estimated.

This affection corresponds in its pathology with hydrorachitis or spina bifida—hydrocele of the spine as it might be called—a collection of water in the membranes of the cord protruding through a congenital deficiency in one of the vertebral spinous processes.

The cause of this collection of water must be either some constant irritation of the arachnoid membrane; or, what is more likely, a want of balance between the secretory and absorbent powers. You know that there is normally a certain amount of cephalorachidian fluid. This was brought to the notice of the profession by an account published by Magendie in 1827, and had never been accurately described before. It is this fluid, existing in superabundance, which gives rise to this increased size of the skull, the bones are forced apart, as the sutures, the fontanelles are widely open.

The physical qualities of the fluid are the same as of the cephalorachidian secretion in its normal state. It is saline, contains just the smallest quantity of albumen, not coagulable by heat, nitric acid or the electric battery. If there was as much albumen here as in the fluid contained in a hydrocele, it might prove disastrous to the brain, and nature has, therefore, wisely kept the albumen away from these important structures.

What is to be done for the relief of this condition? Very little. When the disease has reached such a state as it has in the case before you, nothing remains but the hope for amelioration. The late Dr. Conquest, of England, published a series of cases, in all about fifteen or eighteen, where a cure followed the operation of tapping. I have not the slightest confidence in his statements, for the experience of the entire medical and surgical profession is against his conclusions. If he attained such success in so many cases, it is strange that the same thing could not be done in the practice of other physicians and surgeons. I, therefore, assume that there was no truth in the statement. The late Dr. Brainerd, of Chicago, also published a series of cases, embracing six or eight, in which the best results apparently followed the injection of iodine and iodide of potassium. Drawing off a certain amount of the fluid and injecting a small quantity of a diluted solution, containing iodine and iodide of potassium, was the method advocated by this surgeon, the operation to be repeated every six or eight days, and always preceded by drawing off a small quantity of the fluid. I cannot see upon

what this method depends for its good results, which, in truth, lack confirmation, for they have not been obtained by the other observers who have adopted this plan. I think that he must have been mistaken, although a man of great respectability and unquestioned veracity; yet mistakes will sometimes occur.

Another series of cases has been published by some one whose name I do not at present remember, but his method was based on the internal administration of iodine and the iodide of potassium, something on the plan of Dr. Brainerd. It has been, however, pronounced equally unsuccessful, by subsequent experience. The treatment is no more promising than that for spina bifida. Due attention to hygiene, and little, if any, medicine, is what I shall advise for our patient.

#### Diagnosis and Treatment of Tertiary Syphilis.

Wm. S., 38 years of age, when he was about 17 years old, had three chancres, followed by bubo in the right groin. Subsequently he has had mucous patches upon his lips, but no other manifestations of syphilis, for about thirteen years, until lately. He comes to us now, complaining of nocturnal pains, existing for the last week, in the shafts of the long bones. He also exhibits an indolent, ecchymatous, copper-colored eruption upon the dorsum of the left foot. On his back I also find a few rupial sores. These manifestations are characteristic of syphilis, and are evidently tertiary in their character.

There is no mistaking this disorder, even if the case were presented without a history. When you see such sores, covered with a blackish crust—rupial sores—there is no doubt whatever about the case; but when you couple with it the history of chancres, the evidence is conclusive.

For the relief of the nocturnal pains, and to heal up these sores, we will give him iodide of potassium and bichloride of mercury. We may scotch the syphilitic poison with the iodide of potassium, but if you wish to kill your snake you must also use a certain amount of mercury. I prefer the bichloride as being the most harmless and less likely to damage the patient's constitution. Other mercurial preparations are preferred by some surgeons, calomel, the biniodide, and the green iodide have each their advocates. Blue pill, mercury with chalk, and other preparations are also in use, but I have not the same reliance in them as in corrosive sublimate.

R. Potassii iodidi, gr. x  
Hydrarg. chlor. corrosiv., gr. ½  
Infusi gentianæ comp., fl. 3 ss. M.

For a dose, three times daily.

As the medicine is apt to disagree with the empty stomach, it is best to give it after each meal. If it nauseates, let the quantity be reduced.

Under the influence of these two remedies the nocturnal pains may be relieved in the course of a few days. We should have warm baths (about 85°) every few days, in which might be placed some bran and salt. Let him remain in the bath for half an hour. Keep the skin moist and clean, and apply to the sores some benzoated oxide of zinc ointment, and Goulard's cerate, of each equal parts. The sores on the foot seem more

inflamed and should be wrapped up in some acetate of lead solution. His diet and clothing will also be looked after.

#### Result of Resection of Shoulder-Joint.

The case just shown is also one of surgical interest from another point of view. He has lost about three and a half inches of the upper extremity of his right humerus, from a gunshot wound of the shoulder received in the last war.

The operation of excision of the shoulder joint is often practiced, first, on account of pathological conditions of the humerus and scapula, and secondly, on account of external injury, especially gunshot wounds. The operation is easily done, by making, as I prefer, a perpendicular incision through the deltoid, beginning at the acromion process and passing downward, making a wound about four and a half to five inches in length, directly down to the bone. Then peel off as much of the periosteum as is thought necessary, and cut off its sharp edges with the pliers. The operation was performed in this way, for the perpendicular line of the cicatrix is plainly seen.

He has considerable power of movement in the newly formed joint. He can raise the arm in front to a right angle, although undoubtedly a considerable portion of the bone has been removed. As he has full use of the forearm and hand, you see it is very much better than no arm at all. The operation, he tells us, was performed sixteen years ago, at the close of the war.

### MEDICAL SOCIETIES.

#### PHILADELPHIA LARYNGOLOGICAL SOCIETY.

Stated meeting held on Friday evening, March 25th, 1881, at the house of Dr. Isaac Barton. The president, Dr. J. Solis Cohen, in the chair.

Before the meeting was formally opened Dr. Cohen exhibited a patient with extensive ulceration of the epiglottis and larynx, and Dr. Barton showed a case of congenital syphilis in a young girl involving the nasal, pharyngeal and laryngeal cavities.

After the members had examined the cases the president called the meeting to order. Dr. Barton then read a very interesting paper on "Medicated Gelatine in the Treatment of Nasal Catarrh." (See p. 401, No. 1258.)

Dr. Allen said that in his opinion gelatine was the proper material for carrying remedies and keeping them in contact with the mucous membrane of the nose, and stated that he had found a number of persons greatly relieved from attacks of hay fever by the introduction into the nose of soft pieces of gelatine saturated with iodoform. The subject of nasal catarrh was then at length discussed by most of the members present.

Dr. Seiler then read a report of two cases of pulmonary syphilis which he had been able to diagnose from phthisis and had successfully treated with iodide of potassium and mercury. He stated in his paper that, according to his own experience and that of other observers, syphilitic phthisis was more common than generally sup-



posed, and that the differential diagnosis between this affection and ordinary pulmonary phthisis could only be made out with any degree of certainty by the demonstration of the presence of syphilitic changes in other organs beside the lungs, and especially with the laryngoscope in the larynx.

This paper, together with the cases shown before the meeting, was then discussed by most of the members present, and the question was raised whether the case exhibited by Dr. Cohen was one of syphilis or of tuberculosis of the larynx. The Doctor stated that there was no history of specific infection, or of any of the usual secondary affections, and there was an absence of the intense

injection of the mucous membrane of the palate and fauces so characteristic of syphilis; that there was, on the other hand, a soft tumor the size of a shelled almond in the soft palate, a slight swelling of one of the glands in the left groin, and that the lower portion of the right lung only was implicated to a very slight extent, which, as Doctor Seiler had pointed out in the paper just read, was the usual seat of lung infiltration in syphilitic phthisis. No definite conclusion as to the nature of the case was reached. Doctor McCracken then exhibited several samples of throat lozenges which had been manufactured for him, from his own formulæ. After this the Society went into private session. C. SEILER, M.D., *Secretary*.

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### Treatment of Diphtheria.

Dr. Thomas Barling describes, in the *Michigan Medical News*, February, his treatment of diphtheria. He says:—

I enlarge to four things: 1. Hygiene; 2. General Health; 3. The Throat; 4. Counter-irritation.

1. I insist on great cleanliness of person and surroundings; a moist atmosphere, easily obtained by mopping the floor and keeping a milk pan of water on the stove, and a disinfectant produced by half filling an old milk pan with moist earth, placing it under the stove, and putting into the moist earth fifty or sixty matches (generating ozone) and thirty or forty drops of carbolic acid, renewed three or four times a day.

2. For general symptoms, such as high pulse, pain in back, dry skin, increased heat, general uneasiness, and glandular throat swellings, I give one dose of calomel, five to twenty or thirty grains, followed in about six hours by a dose of castor oil.

3. The throat. At the commencement there are swollen tonsils, greatly enlarged capillaries, quickly followed by the diphtheria effusion, always accompanied with an increase of temperature of from two to four or even five or six degrees. I combat this with cold. I give a solution of

|    |              |          |
|----|--------------|----------|
| R. | Acid. tart., | gr. iij  |
|    | Pot. chlor., | gr. iij  |
|    | Water,       | ℥ ij. M. |

Order one teaspoonful to be mixed with two teaspoonfuls of the coldest water they can get; if ice water, so much the better; if no ice is to be had, cold well water, readily to be obtained, at about 45° or 56°; two teaspoonfuls are to be used as a gargle and the remainder swallowed. This to be repeated every twenty or thirty minutes, till the urgent symptoms subside. Little four year olds will eagerly look out for the gargle and long for the time for its repetition. I use no spray, no tannin, no swabbing, but I expect the urgent symptoms to be relieved in about twenty-four

hours. I then generally give a gargle composed of

|    |              |           |
|----|--------------|-----------|
| R. | Red pepper,  | 10 grs.   |
|    | Common salt, | 30 grs.   |
|    | Water,       | ℥ teacup. |

To be used freely, and if the tonsils remain enlarged and flabby, finish off with two or three applications of a strong solution of nitrate of silver, three or four grains to the drachm, applied with a feather.

4. Counter-irritation. There is well nigh always severe glandular swelling of the throat externally. I attack this by local sweating. I procure generally a handkerchief, fold it so that it will lay well into the throat, wet the handkerchief in hot water, so hot as almost to scald, and sprinkle it with a teaspoonful or two of kerosene, place this quickly on the throat, and cover with a dry cloth. This may want renewing three or four times at intervals of six or eight hours. This will blister severely; when this effect is produced still continue the wet compress, but put a little sweet cream on the wet cloth instead of kerosene.

This mode of treatment with me cures diphtheria. My total deaths did not amount to five per cent.

#### The Viburnum Prunifolium in Uterine Diseases.

Dr. E. C. Mann writes to the *Boston Medical and Surgical Journal*, February 24:—

As many cases of diseases of women occurring in connection with nervous diseases are annually treated here, I desire to call attention to my own investigations with this comparatively new medicine. It appears to me to act directly and specifically upon the special nerves of the uterus as a true nerve sedative. I have had several very violent cases of congestive and neuralgic forms of dysmenorrhœa, in one case the dysmenorrhœa being accompanied by epileptiform convulsions of a very severe type, and in each and every case I have seen almost magical relief following the use of the fluid extract of viburnum prunifolium. The case referred to, which was so severe that the intensity of the pain had worn out the unhappy sufferer and induced the epileptiform at

tacks, was completely cured in a few weeks by the combined use of the *viburnum prunifolium* and the use of the constant current of electricity, the positive pole being applied to the hypogastric region, and the negative pole, to which was attached a cup shaped electrode, directly to the uterus. The galvanic current has a very powerful influence in suspending contractions of the uterus, and also is very efficacious, when used locally over the ovaries, in controlling ovarian neuralgia. Previous to my using *viburnum prunifolium* I had been accustomed to rely on valerianate of zinc and fluid extract of gelsemium, with the constant current of electricity, but since my first experience with the former drug I have used nothing else. Although I have not had occasion to use it in cases of threatened abortion, I should deem it worthy of use from its action on the ganglionic nerve of the uterus. I have failed to perceive any action on the general system, the whole force of the medicine appearing to be directed to the uterus and its system of nerves. When the pulse has been high, from nervous excitement, and the temperature centres in the brain have been temporarily paralyzed, allowing sudden rise in temperature, from nervous excitement, both pulse and temperature have fallen to the normal as the uterine pain has been relieved. It must be remembered, also, that my cases have been aggravated ones, many of my cases having been sent to Sunnyside on the verge of insanity. My conclusions, therefore, are, that in *viburnum prunifolium* we have a uterine sedative more powerful than any other in controlling dysmenorrhœa and uterine contractions, and that it probably acts by passing from the blood to the nerve centres, and is special in its effect upon the ganglionic nerves of the uterus.

#### Earache and Its Treatment.

The following is from an article in the *Canada Lancet*, by G. S. Ryerson, M.D., L.R.C.P.S.E., Toronto, Lecturer on the Eye, Ear and Throat, in Trinity Medical College, Toronto:—

Pain in the ear may depend upon inflammation of the external auditory canal, the middle ear, or upon neuralgia. Inflammation of the external auditory canal may be diffused or circumscribed. When diffused, the auditory canal is greatly swollen and may be completely closed. It is hot, dry, and covered with dry flakes of epithelium. It is pale red in color and has a puffy or œdematous look. Pain is considerable, but the patient is as much distressed as suffering. Moving the auricle, or touching the part causes increase of pain. The hearing is dull and there is much tinnitus, roaring and throbbing.

The causes are exposure to draughts; irritation of a foreign body, as a plug of wax, and imperfect drying of the ear after bathing. A chronic form may be induced by the bad habit of picking the ear with pins.

The treatment is simple; it consists, in the early stage, of inflating the middle ear with Politzer's air bag, thus opening up the Eustachian tube and permitting the accumulated fluids to escape. Filling the ear with warm water will often give relief. Eight to ten drops of atropia

sulph. grs. iv, aq.  $\frac{3}{j}$ , should be instilled in the ear every two hours. A leech applied to the tragus will give great ease. The wound should be encouraged to bleed for some hours after the leech has fallen off. Should the patient be seen later, when there is much bulging of the drum-head, paracentesis should be done, with good illumination by a head mirror. This at once relieves the intense pain, saves the drum from loss of substance, and the ossicles from displacement. It also heals up more readily than when ulcerated. Should the drum have burst before the practitioner is called in, acid boracic, grs. xv, ad aq.,  $\frac{3}{j}$ , and zinc. sulph., grs. v. ad aq.  $\frac{3}{j}$ , will be found to gradually arrest the discharge. The ear should be frequently syringed and the greatest cleanliness observed. *Poultices should never be applied to the ear.* Laudanum and oil are of little use. It also frequently follows measles and scarlatina. Neuralgia of the ear is rarely met with, and then in nervous women. It does not differ essentially from neuralgia in other parts. There is sometimes abnormal sensibility to sound present, more often, however, deafness. The treatment is principally tonic. There is no special local treatment which can be relied upon.

#### The Diagnosis of the Forms of Insensibility.

In a lecture in the *Lancet*, Dr. Reginald Southey says:—

In every case of coma count the respiration, observe the quality of the breathing, and its ordinary effect upon the blood by the color of the lips. Examine the pulse carefully for quality, frequency, regularity. Touch the eyeballs, examine the pupils for reaction to light, their condition—dilated, contracted, unequal, irregular; tickle the soles of the feet, to test what amount of reflex muscular action can be coordinated. The breathing in most states of coma is heavy and slow; notice if it be stertorous, Cheyne-Stokes like, wholly diaphragmatic, or if the intercostals act. Next take temperature in the axilla or rectum. A remarkably low temperature, four degrees or more below normal, betokens usually uræmic coma, acetonaemia, or grave concussion of the brain. After epilepsy, apoplexy, intoxication, the temperature is more often normal, or even slightly above normal.

Uræmic coma will again be separately distinguished most often by some slight œdema of eyelids or extremities; waxlike pallor, bronchitic sounds, very foul breath, smelling of beef tea; a brown, furred tongue, pearly conjunctivæ, and dilated pupils bespeak urea poisoning. Diabetic coma is indicated by oppressed, noisy breathing, effected by abundant muscular effort, but attended by some lividity, in evidence of impaired oxidizing changes at the pulmonary capillaries, of which we do not at present understand the exact cause.

In the coma that has succeeded an epileptic fit you may expect to find bruises, torn or dirtied clothes, indications of the tongue having been bitten.

Finally, the mode of recovering consciousness after intoxication differs much from what is observed in persons recovering from the coma that

succeeds an epileptic fit. After intoxication I have noticed that while the sense of hearing is recovered soon, the lower attributes of mind, the sensorial instincts, reappear early; the individual who was comatose drunk hears correctly before he sees correctly, and sometimes before he can stand. It is curious to notice the manner in which he repeats a word of your question over and over again, like a parrot, and perceive how some grotesque idea grows out of the jingle or jangle of a phrase mumbled over more or less thickly.

How differently do the mental faculties recover after brain concussion and commotion, as after epilepsy. How the intellectually reduced "egomet," is in a dreamy state and staggers in his gait, hears questions put to him correctly, answers them articulately, apparently rationally, but having done so straightway forgets what he has said, cannot tell where he is or what he is or was doing. He is conscious of some confusion in his own memory, and shows often some high measure of judgment in his distrust of himself, and says, "I cannot recollect where I was going."

It remains for me to point out the distinctive features of opium coma. There is profound stupor, with closed eyelids, contracted pupils, upturned eyeballs; the face is pale; the skin cool, clammy; the forehead beaded with heavy perspiration; the limbs are lax, but, for a while, reflex motions are readily excited. The respiration now slackens, falls in frequency, perhaps, as I have seen it do, to as low an ebb as six per minute, the pulse remaining fair at eighty. The coma now is very profound; you may prick, stimulate by galvanism, call, flick, stimulate by what means you please, little or no further purposive response is returned by coördinated muscular movements. The body will not walk; it is only dragged about, if the advice given has been to walk the man about. Next the lips get livid; the surface of the body colder; the breath is sobbing, and at long, irregular intervals; the pulse hardly to be felt at the wrist, and death is imminent by asthenia or sudden failure of the heart's action. Now for what may you mistake this coma, and what may be most easily confounded with it? Apoplexy into the pons Varolii, since, as was pointed out long since by Dr. Wilks, who illustrated the fact by several examples of cases that had fallen under his observation, apoplexy into the pons is attended by great contraction of the pupils.

#### The Effects of Varicocele on the Testicle.

Varicocele is so frequent that some observations made this past winter by Mr. P. Gould, and reported to the Clinical Society of London, will have general interest. Mr. Gould exhibited two men to the Society, each presenting a large left varicocele, with the testicle on the same side much smaller than its fellow, but retaining its usual firmness, outline, and testicular sense. The one man, aged 18, had noticed the swelling in the scrotum accidentally, four or five months ago. The other, aged 17, had noticed the varix for six or seven years. In neither case was

there any pain or disturbance to be traced to the varicocele. Neither patient had suffered from inflammation of the testicle or any injury to the scrotum. They were both well made, robust, healthy-looking men. Mr. Gould quoted the views of Sir James Paget and Mr. Curling, as illustrating the opposing doctrines on the question whether varicocele did or did not cause wasting of the testicle. After enumerating a list of authors who supported Curling in his opinion that atrophy of the testicle did result from varicocele, he observed that many of the cases cited in support of this assertion must be excluded, on account of the traumatic origin of the varicocele; wherever there was a history of injury or inflammation, it was impossible to say that the change in the testicle was not the direct result of such injury or inflammation. Again, cases where there was no mention made of the presence or absence of these conditions were also of doubtful value. With these reservations, the alleged cases of atrophy were of three kinds: first, cases of arrested development of the testicle, illustrated by the cases shown; second, cases of very slight lessening of the size of the testicle, said by many authors to be very common; a condition of which it was difficult to be certain. Mr. Gould had never seen the left testicle larger than the right—its normal relation—when there was a large varicocele on the same side. Thirdly, there were cases of morbid and extreme softening and wasting. Although cases of this kind were recorded by Curling, Richter, Landouzy, and others, no mention had been made of the absence of previous injury or inflammation of the testicle; and they were not entirely free from doubt on that account. There was strong reason to think that varicocele might produce such wasting of the gland. Referring to the frequency of varicocele on the left side, Mr. Gould argued that neither the greater length of the spermatic vein on that side, nor its lying beneath the sigmoid flexure, nor the mode of entrance into the left renal vein, was sufficient explanation. It was maintained that the use of the valve at the mouth of the spermatic vein was to convert the direct opening into an oblique aperture, and, by lessening its size, cause the flow of blood over it to exert an aspirating effect. Many differences between varicocele and other external varices were pointed out; and the opinion was advanced, that many cases of varicocele were nœvoid in character—a primary abnormal development of the veins.

#### Gelsemium in Incipient Epilepsy.

Drs. A. W. Wiseman and W. L. Crump say, in the *Virginia Medical Monthly*, February, 1881:—

We attended together a case of cerebro-spinal meningitis in a young married woman, nursing her third child, which was a few months old. The patient's parents on both sides were strumous. The case was complicated by slight typhoid symptoms. After convalescence from the meningitis was fairly established, she commenced having epileptic fits. We tried chloral, morphia and bromide of potassium, the last.

named remedy being pushed to the degree of causing nausea, yet without any beneficial effect. We saw that unless something more was done we would have a case of confirmed epilepsy to deal with; we put her upon the fluid extract of gelsemium, three drops every two hours, and gradually increased the dose to nine drops. Amendment was noticed in two days, and in one week the fits ceased. Several months have elapsed, with no return of the disease.

In a case of hysterio-epilepsy, in an unmarried colored girl of about twenty (menstruation normal), with intense clonus hystericus and hemianesthesia, which had been a very troublesome case at different times, we pushed the gelsemium until fifty-eight drops were taken every two hours, for days together, with the effect of quelling the paroxysms. A few mild attacks came on afterwards, but were controlled by the medicine, and they gradually subsided, and for several months there has been no return.

The range of the dose is considerable, for during the same time that we were treating the last-mentioned case, one of us treated a rather sthenic case of pneumonia in a young married woman, nursing her third child, which was a few months old, and four drops produced the peculiar constitutional effects of the drug. The patient rested as quietly as if she had been asleep, and afterwards said that she could hear the attendants discussing whether she was asleep, and sometimes she could hear some of them say "Now I know she's asleep." And yet the pulse was only reduced from 120° to 112°.

#### The Diagnosis of Jaundice.

The following useful epitome is taken from Dr. J. W. Legg's late work on Bilious Diseases. It gives his directions regarding the diagnosis of jaundice:—

1. Should the jaundice be recent, and no perceptible disease be found in the liver or elsewhere, the case is probably one of simple jaundice.

2. The jaundice being recent, but acute disease of other parts present, such as pneumonia, pyæmia, typhoid and relapsing fevers, and the like; delirium tremens, poisoning by chloroform, chloral hydrate, and other drugs, and snake-bites, the cause of jaundice is not known with any certainty; but it is probably the same as in simple jaundice.

3. If the jaundice be accompanied or preceded by attacks of severe shooting pains in the right hypochondrium; or if the jaundice be intermittent, one attack quickly succeeding the other, the cause is probably gall-stones.

4. An intense, persistent jaundice, if approaching twelve months in duration, is due, probably, not to cancer, but to gall-stones, hydatids, or stricture of the duct.

5. A slight, persistent jaundice is probably due to changes in the texture of the liver, as cirrhosis, nutmeg liver, etc.

6. Jaundice with great enlargement of the liver is probably due to cancer.

7. Jaundice complicated with ascites is probably due to cirrhosis.

8. Delirium setting in during an acute jaundice suggests *icterus gravis*.

## REVIEWS AND BOOK NOTICES.

### NOTES ON CURRENT MEDICAL LITERATURE.

—A very neatly gotten up and curious addition to medical literature, is a series of phototypes of bogus diplomas, bought for \$455.00, in May, 1880, by a representative of the *Philadelphia Record*, "who had no knowledge of medicine and had never seen the inside of a Medical College." It contains phototypes of a diploma of the "Eclectic College of Pennsylvania," of a certificate of membership of the "National Eclectic Medical Association," a diploma of Doctor of Laws, of the "American University of Philadelphia," one of "Doctor of Divinity," of the same institution, one from the "Livingstone University of America," and one from the "Philadelphia Electropathic Institution," conferring the degree of "Master of Electro-Therapeutics" (Drs. Galloway and Bolles' concern). All these were bought outright, by a person wholly ignorant of medical science.

—The address delivered before the graduating class of the Medical Department of the State University of Iowa, by Dr. S. B. Chase, has been published in neat form, by the class. The subject is "Our Life Work," and it is well treated.

—Various papers contributed to the *Boston Medical and Surgical Journal*, by Dr. Thos. H. Buckler, of Baltimore, have been collected and published by Houghton, Mifflin & Co., Boston (paper, pp. 72).

The topics are "Strangulated Veins of the Uterus," "Post-parturient Pathology," "Free Access to the Abdominal Cavity," etc.

—Dr. Rosalino Rovira y Oliver, of Barcelona, has sent us his thesis on pneumoconiosis, or the effects of the inhalation of dust. He dissents strongly from various French authorities, who have spoken of the effects of dust in the lungs as trivial. On the contrary, the inhalation of dust consisting of sharp spiculæ leads to a dangerous irritation of the lung substance, the patient often dying with one of the forms of phthisis. He draws a broad distinction between the effect of such dust and that which is composed of soft particles. The whole thesis is carefully prepared, and indicates original study of the subject.



—A series of statistics of the weight and size of the body and its organs has been prepared for the use of medical students, by Dr. J. S. Wight, Professor of Surgery at L. I. College Hospital, and published by Trendett & Co., Brooklyn. It makes a neat pamphlet of twenty-six pages, and is useful for reference.

—The annual report of the German Hospital for this city indicates the institution in a flourishing condition.

# BOOK NOTICES.

**The Metric System in Medicine.** Containing an account of the Metric System of Weights and Measures, Americanized and simplified, a Comprehensive Dose Table, and practical illustrations of Metric Prescriptions. By Oscar Oldberg, PHAR. D., etc. Philadelphia: Presley Blakiston, 1881. Cloth, 8vo. pp. 182. Price \$1.50.

The contents of this volume are quite fully set forth in the comprehensive title which we have above quoted. It is addressed both to pharmacists and physicians who wish to familiarize themselves with the metric system as it is recommended by its advocates for introduction into this country—"Americanized," as Dr. Oldberg calls it. The arrangement and contents of the work are well adapted for this purpose. A historical sketch of its earliest introduction into the United States is given, and a number of rules for the ready conversion of the usual apothecary's into metric weights and measures are advanced. The posological table is very complete, and the metric formulary will be welcomed by any who wish to familiarize themselves with accurate metric prescriptions. Of the several adaptations of the metric measures to the supposed wants or wishes of the American medical public, this is no doubt the most approved and the only official one, inasmuch as it has already been adopted by the U. S. Marine Hospital Service, in which the author is Medical Purveyor.

**A Manual on Diseases of the Eye and Ear.** For the use of Students and Practitioners. By W. F. Mittendorf, M.D., Surgeon to the New York Eye and Ear Infirmary, etc. Illustrated. G. P. Putnam's Sons. 1881. Cloth, 8vo, pp. 445. The author of this work has designed it to be a short and practical manual of the diseases of the organs of which it treats, designed primarily for students and those practitioners who have time to make but a cursory study of these special branches. He has succeeded in presenting a

large number of these maladies, all, in fact, which are usually met with, writing as fully as possible on their description, treatment and differential diagnosis. His arrangement is the simple anatomical one. Beginning with the orbit, he speaks of the lids, lachrymal apparatus, muscles of the eyeballs, the conjunctiva, cornea, etc. There are a moderate number of wood cuts and ten full-page plates, colored lithographs, taken from the works of Sichel, Liebreich, and Wells. These plates, though at first glance an attractive feature of the book, are, with two exceptions, of little practical value, and they are not executed with any great amount of skill. Nor can we say much in praise of the wood-cuts; they are rough and too few to be of any real use to the reader.

Four chapters, in all about a hundred pages, are devoted to the diseases of the ear. The directions for using the ophthalmoscope and otoscope are somewhat scanty, and, especially the former, might have been bettered by the more free use of illustrations, and a much more detailed description of the procedures necessary.

**A Guide to the Clinical Examination of Patients and the Diagnosis of Disease.** By Richard Hagen, M.D. Translated from the Second Revised and Enlarged Edition, by G. E. Gramm, M.D. Boericke & Tafel, Philadelphia. 1 vol., cloth, pp. 223.

We have known and appreciated Hagen's work for a long time. It has met with considerable success in Germany, and has held its own as a student's guide to diagnosis for a number of years. But why did the present translator take the *second* edition, published as far back as 1873, for his translation, when a *third*, with important additions, appeared in 1877, and perhaps yet another later than that? Such neglect to obtain the latest improvements of the author is censurable.

The volume begins with some introductory remarks on symptoms and general definitions. The reader is then instructed in the general clinical examination of the patient, his previous history and his *status præsens*.

The rules for special clinical examinations are divided into those for patients presenting symptoms pointing to a disease of the lungs, the heart, the abdominal organs, the brain, the skin, the spinal cord, poisoning, etc. The directions given are clear and concise, and the book is a valuable addition to the literature of diagnosis.

It is neatly printed, with a full alphabetical index, and the translation is fairly well made.

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## THE CONSUMPTION OF OPIUM IN THE UNITED STATES.

The enormous consumption of opium in the United States is naturally attracting the attention of those familiar with our commercial statistics. Of the entire crop of Turkish or Smyrna opium we use considerably more than half. The whole of Europe takes only about three-eighths of it. The actual weight in pounds is 372,000. About a quarter of this is used in the manufacture of morphia, of which we may suppose 80,000 or 100,000 ounces are made and consumed inside our borders.

There has also been recorded a steady and rapid increase in the demand for opium in the United States; an increase much out of proportion to that of our population. This is evident from the following table of imports in different years:—

|          |             |
|----------|-------------|
| In 1859, | 71,839 lbs. |
| 1860,    | 135,000     |
| 1867,    | 135,305     |
| 1876,    | 228,742     |
| 1877,    | 230,102     |
| 1878,    | 207,752     |
| 1879,    | 278,554     |
| 1880,    | 372,000     |

Here is an increase of four or five hundred per cent. in twenty years.

These estimates were furnished the *American Journal of Pharmacy* last December, by Mr. R. F. FAIRTHORNE, of this city. He adds:—

“Why so much larger quantity is consumed in this country than in Europe it would be difficult to determine. The greater number of persons suffering here with neuralgic troubles cannot possibly account for it. It is time that every physician and druggist should use his utmost efforts to restrain the improper use of opium. Undeserving, indeed, is he of the name of good citizen who carelessly dispenses these or other pernicious drugs for the sake of paltry gain.”

Such a warning is indeed timely. It is impossible to resist the conviction that the “opium habit” is silently and secretly extending itself among our population. We believe that it prevails more widely than is generally credited. Very many persons indulge for years in small quantities of opium daily, merely as a stimulant.

It is a mistake to suppose that opium-eating, or the abuse of the drug in any of its forms, certainly leads to great excess in it. On the

contrary, most opium consumers are not opium debauchees, any more than most of those who use alcoholic beverages become drunkards. Whatever temperance orators like to say, such is not the case. By far the majority of moderate drinkers continue moderate to the end of their lives. They do not become sots, and feel no temptation that way; but they like their tippie for all that. So it is with opium. The most reliable English medical observers in the East agree that the "frightful examples" of opium victims are rare, and the habit is by no means so generally destructive as some have made it out to be, and as the popular impression is—an impression, we must say, encouraged in the popular mind by some enthusiastic physicians, who should know better. Thus, in a recent number of the *Popular Science Monthly*, Dr. FELIX L. OSWALD expresses himself in this style on the subject:—

Your body becomes an opium machine, a physiological engine moved by poison, and performing its vital functions only under the spur of the unnatural stimulus. But by and by the jaded system fails to respond to the spur, your strength gives way, and, alarmed at the symptoms of rapid *deliquium*, you resolve to remedy the evil by removing the cause. You try to renounce stimulation, and rely once more on the unaided strength of the *vis vitæ*. But that strength is almost exhausted. The oil that should have fed the flame of life has been wasted on a health-consuming fire. Before you can regain strength and happiness your system must *readapt* itself to the normal condition, and the difficulty of that rearrangement will be proportioned to the degree of the present disarrangement; the further you have strayed from nature the longer it will take you to retrace your steps.

This is set forth as the usual result of small indulgence. It is a greatly-overdrawn statement, and we gravely doubt about the propriety of presenting this as the result of science; or rather, we have no doubt at all on the subject, firmly believing that all species of misrepresentation should be avoided, as ultimately hurtful to a good cause.

On the other hand, no one should underestimate the injury which opium does work on many minds and bodies. It is so great and so enduring that active repressive measures of the opium trade should be taken in every State. No form of the drug should be

sold except by a physician's prescription. It should be classed with poisons, and thus be placed out of the reach of the public. The patent medicines which contain it should be prohibited, and general information as to the dangers run by those who consume it should be disseminated.

There is no question but that the better class of pharmacists would assent to such measures, and would actively aid in having them carried out.

#### THE RELATIONS OF HYBRID MARRIAGES TO SEX IN OFFSPRING AND FECUNDITY.

The observations which we made in a recent number, on the rules for the decision of sex in the human species, explain some curious facts which have impressed students of statistics.

One of these is the preponderance of females among what may be called human hybrids—the children of marriages in which the father and mother belong to different races, as the black and white, or the red and white. This has lately been brought to the notice of the profession by Prof. HARVEY L. BYRD, of Baltimore. In the October number of the *Independent Practitioner*, he says:—

"A curious and interesting fact in regard to the admixture of blood as it occurs in the human hybrid—mulatto—seems, so far as I have learned, to have escaped the notice of those who have written on the subject of the interbreeding of the Caucasian and Negro races."

The fact he alludes to is the one above mentioned, and his observation, though not so novel as he believes, has additional value as an independent corroboration of that of others.

The like has been noted of mixtures between the American Indians and whites. Thus, Mr. STEPHEN POWERS writes: "A noteworthy phenomenon with regard to California half-breeds, which I have observed, and which has been corroborated by others, is that the girls generally predominate. I have often seen whole families of half-breed girls, but never one composed entirely of boys, and seldom one wherein they

were the more numerous" (*Tribes of California*, pp. 149, 403).

The explanation of such facts, according to the hypothesis of Dr. MORTIMER GRANVILLE, (see REPORTER, as above) would be that the prevalence of females indicated greater sex force on the part of the corresponding parent. In his opinion it would indicate a want of fulfillment of the full intention of nature. His views are thus stated in the *Lancet*, December 18th, 1880:—

1. Sex is the result of an arrest or repression of the force of development in the case of the female. The male of every family in the animal kingdom is the best and fullest specimen of development, having regard to the purposes and habits of life of the species, class, or family. In those apparent exceptions where the male is the smaller and less *displayed* animal, that is because it is an advantage in regard to the *life* and habits of the class to be small and unobtrusive.

2. The arrest in point of development which characterizes the female has nothing in common with immaturity, and is; therefore, not a conclusive proof of inferiority. It is, as it were, a *repression* of the formative force, and the physical result of this repression is a perpetual effort to develop or reproduce. The force arrested in the individual gathers intensity, so to say, and expresses itself in a perpetual and characteristic longing to produce a perfect animal. The perfection denied or inhibited in the individual is sought in the progeny. Hence the natural tendency of the female to produce male children, and, as a necessary result, the majority of children born are males. It is not a question of the comparative *amount* of ardency in the two sexes, but of the direction of the force or intention—I do not now mean conscious intention, but the intention or purpose of nature—in the case of the female. This direction will always be followed in sex determination unless that force is neutralized by the male.

3. The function of the male is not one of production, but of fecundation. The tendency of what I have called *ardency* in the performance of this function is to neutralize or control the productive force of the female, and thus determine that *arrest* of development which results in female offspring.

We are far from subscribing to the theory here proposed. On the contrary, many serious objections arise to it.

Mr. POWERS, in the work from which we have quoted, refers to the fact that in nearly all mixed marriages it is the male of the higher race who selects the female of the lower race; but, also, that the male is very apt to be a poor and degraded specimen of the higher race, while the female is nearly sure to be an unusually attractive

and favorable specimen of the lower race. It is she who possesses the greatest amount of reproductive power; and possibly for this reason impresses her sex on her offspring.

The statement is made by PRITCHARD and others, that when women of the lower races—especially of the Malasian races of the Pacific islands—have once conceived by a white man, they do not at all, or they do with much less readiness, conceive by a male of their own race.

This is one cause of the rapid disappearance of the native population from those islands.

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Such occurrences are rare, but we believe there are in the human race some few cases recorded where twins seemed to indicate that they owed their life to fathers of different races, the negro and the white, for example.



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Dr. Aveling stated that since he had invented his repositr, last year, five cases had been successfully treated by it.

were the more numerous" (*Tribes of California*, pp. 149, 403).

The explanation of such facts, according to the hypothesis of Dr. MORTIMER GRANVILLE, (see REPORTER, as above) would be that the prevalence of females indicated greater sex force on the part of the corresponding parent. In his opinion it would indicate a want of fulfillment of the full intention of nature. His views are thus stated in the *Lancet*, December 18th, 1880:—

1. Sex is the result of an arrest or repression of the force of development in the case of the female. The male of every family in the animal kingdom is the best and fullest specimen of development, having regard to the purposes and habits of life of the species, class, or family. In those apparent exceptions where the male is the smaller and less displayed animal, that is because it is an advantage in regard to the life and habits of the class to be small and unobtrusive.

2. The arrest in point of development which characterizes the female has nothing in common with immaturity, and is; therefore, not a conclusive proof of inferiority. It is, as it were, a repression of the formative force, and the physical result of this repression is a perpetual effort to develop or reproduce. The force arrested in the individual gathers intensity, so to say, and expresses itself in a perpetual and characteristic longing to produce a perfect animal. The perfection denied or inhibited in the individual is sought in the progeny. Hence the natural tendency of the female to produce male children, and, as a necessary result, the majority of children born are males. It is not a question of the comparative amount of ardency in the two sexes, but of the direction of the force or intention—I do not now mean conscious intention, but the intention or purpose of nature—in the case of the female. This direction will always be followed in sex determination unless that force is neutralized by the male.

3. The function of the male is not one of production, but of fecundation. The tendency of what I have called *ardency* in the performance of this function is to neutralize or control the productive force of the female, and thus determine that *arrest* of development which results in female offspring.

We are far from subscribing to the theory here proposed. On the contrary, many serious objections arise to it.

Mr. POWERS, in the work from which we have quoted, refers to the fact that in nearly all mixed marriages it is the male of the higher race who selects the female of the lower race; but, also, that the male is very apt to be a poor and degraded specimen of the higher race, while the female is nearly sure to be an unusually attractive

and favorable specimen of the lower race. It is she who possesses the greatest amount of reproductive power; and possibly for this reason impresses her sex on her offspring.

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#### The Increase of Accidental Deaths.

A recent English author, Mr. Walford, lately reviewed the numbers and causes of deaths of this class from the earliest periods at which records existed in Great Britain, bringing them down also to the latest date, and noting the circumstances which had helped to increase them, and also those which had a retarding influence. Mr. Walford is of opinion that these statistics show that violent deaths of various kinds have advanced with the progress of civilization. New forces, as also increasing mechanical productiveness, render the risk to life and limb continually greater. The five great divisions in deaths of this class are those caused respectively by railways, in the working of mines, by mechanical injuries, by chemical fumes and compounds, and by asphyxia (or stifling and drowning).

Here is a wide field for sanitation in rendering these forces less dangerous.

#### Hot Baths in Asphyxia of the Newborn.

In a communication to the Académie des Sciences, M. Goyraud calls to mind that M. Gustave Le Bon, in a note published in the *Comptes-Rendus* of 1872, indicated as a certain method of recalling to life young animals which had become asphyxiated the plunging them into a bath the temperature of which was gradually raised from 38° to 48° Cent. M. Goyraud has recently had occasion to employ this means for a newborn infant which had been delivered by the forceps. When the infant was extracted, the movements of the heart had entirely ceased, and various means for restoring animation, including artificial respiration, were persevered in for nearly two hours. No sign of life appearing, the infant, already become cold, was plunged into a bath heated from 45° to 50° Cent. (113° to 122° Fahr.). Thirty seconds had hardly elapsed when the first inspiration was observed to take place, and was quickly followed by free respiration, the infant in the course of five minutes having become full of life.

#### Chromicized Catgut Ligature.

In a recent lecture in Glasgow, Dr. Wm. MacEwen said:—

Carbolized gut softens, and yields in about forty-eight hours, and therefore in certain cases it may be necessary to use a ligature which would maintain its constricting force for a longer period.

With a view of obtaining a ligature which would serve this end I made, during the past few years, a series of experiments with catgut pre-

pared in chromic acid and glycerine; and without going into detail concerning these investigations, it is sufficient to say that ligatures were obtained which admirably serve the purpose for which they were intended. They are prepared by making, first, a watery solution of chromic acid, one to five; then one part of this solution is added to twenty of glycerine. This forms a dark greenish compound, in which the hanks of catgut are inserted and retained for seven or eight months, the bottle containing them being occasionally shaken. At the end of this time the catgut acquires a semi-translucency, and has a dark color like preserved ginger. It is then ready for use, and is stored in a solution of carbolic acid and glycerine (one to ten). The size of the catgut which is of most use in the ligation of large arteries (excluding such as the innominate) is the medium, and this size has been very frequently tested since 1877. In the shape of deep sutures, this gut has been, and, as you see, is daily being used in the wards. In this way we are enabled to ascertain its behavior while in contact with the living tissues, and it has been very satisfactory.

#### The "St. Gothard Tunnel" Disease.

The workmen in the St. Gothard tunnel have been subject to an intractable, fatal anæmia, which destroyed many and puzzled the physician. At last, its nature has been discovered. It has been definitely traced to the fatal influence of a parasitic, nematoid worm, very prevalent in hot countries, especially in Egypt, where it causes the disease known as "Egyptian chlorosis." The presence of this noxious worm was only lately recognized as the cause of the cases of debility and impoverishment of blood epidemic among the workmen. How it was introduced there is not known. The ova develop out of the body and are taken in in the drinking water. The parasite in question is the intestinal leech, the *anchylostomum intestinale*. It is not wholly unknown in this country. See the *MEDICAL AND SURGICAL REPORTER*, vol. xli, p. 40.

#### Benzoate of Soda in Rheumatism.

A number of cases of acute rheumatism treated with benzoate of soda are detailed in the *Brit. Med. Jour.*, March 5, by Dr. David Macewen. The dose given was fifteen grains every three hours. The results were quite gratifying, and seem to promise that this drug will prove a remedy of considerable efficacy in the treatment of this painful disease.



## SPECIAL REPORTS.

## NO. IX.—OPHTHALMOLOGY.

BY C. S. TURNBULL, M.D.

(Continued from page 416.)

HOLMGREN observed in a decapitated criminal contraction of the pupil five minutes after the execution, and dilatation of the pupil only after two minutes more (Upsale Läk. Förel., 1879).

BERLIN, in referring to *Anomalies of Refraction and Accommodation in the Eyes of Animals*, says:—

"In a large number of different domestic animals the refraction was mostly hypermetropic. Myopia was sometimes found in horses. In most of the larger animals irregular astigmatism of the lens could be demonstrated (Ophth. Section der Naturforscher-Versammlung in Baden-Baden, September, 1879, Z. M., 1879, p. 493).

MALAREWSKY, at the meeting of the Russian Society for Hygiene, spoke of "*A Page of a Book and its Influence upon the Scholar*." He recommends to print white letters upon black background.

BECKER contributes a case of congenital, one-sided, total color-blindness (A. f. O., vol. xxv, 2). This first accurately and fully-examined case of monolateral color-blindness refers to a girl of 17, in whose family there were color-blind males.

BRIBOSIA found that among 825 persons, about three per cent. were color blind.—Internat. Med. Congr., Amsterdam, Z. M., Vol. xvii, p. 406.

BURNETT gives us the *Results of an Examination of the Color-sense of 3040 Children in the Colored Schools of the District of Columbia* (A. O., Vol. viii, p. 191):—

Among 1691 colored girls, two were color-blind—0.11 per cent.; of the 1349 colored boys, 22 were color-blind—1.6 per cent. Compared with the percentage of color-blindness in school children, found by Magnus, the negroes show a smaller percentage of color blindness.

He has also devised a *Systematic Method for the Education of the Color-sense in Children* (Washington, September 25, 1879):—

He comes to the following conclusions: "The reduced color sense, which does not depend upon an abnormal structure of the color-perceiving apparatus, but only upon an insufficient development of a dormant force, can be sharpened by systematic education. The really color-blind patient can be improved by training, but it may surely be expected that by practice continued during several generations, the tendency to color-blindness can be considerably weakened. Burnett's system of training is essentially only a modification of the one proposed by Magnus. The colors which Magnus prepares by lithography are furnished by colored worsted, which are arranged on a plate."

Dr. S. M. Burnett strikes the key-note in suggesting the education of the color-sense in children. The fact of want of education, *i.e.*, practice of the color-sense is, in our opinion, the sole cause of color-blindness, when other than a pathological symptom. Perhaps, too, some of the children might have been taking santanine as a vermifuge.

COHN, in speaking of the *Quantitative Determination of the Color-sense in Europeans and Nubians* (Schles. Ges., Aug. 1, 1879; Schles. Zeit., No. 372, and Allg. Med. Centralzeit., Aug. 30, 1879), says:—

The color-sense of Nubians is normal, but their nomenclature is incomplete. Acuteness of sight much higher than 1.

Determination of the color-sense by direct sunlight, and by electric light (Ber. d. 12 Vers. d. Ophth. Ges. Z. M., Vol. xvii, p. 6). The distances at which most colors are recognized by electric light are considerably greater than by good daylight.

GATSCHET, in speaking of *Adjectives of Color in the Indian Languages* (The American Naturalist, August, 1879; A German Translation in *Zeitch. f. Ethnologie*, Vol. xi, H. 4, u. 5), says:—

Seven Indian tribes of North America were examined with colored strips of paper. The expressions for green and yellow, red and yellow, yellow and brown, brown and red, were sometimes not distinctive by the Indians of North America as well as by those of South America; green and yellow were most frequently expressed by the same word. Otherwise the Indians distinguish very many shades of color.

KOTELMAN, by way of curiosity, notes that of the eyes of 9 Laplanders, 3 Patagonians, 13 Nubians, and 1 negro from the White Nile (Berl. Klin. Wochenschr., 1879, No. 47), the color-sense was well developed; names of colors uncertain; acuteness of sight much greater than 1.

MANZ mentions some of the *Effects of Fuchsine glasses*. (Ophth. Section der Naturf. Vers. zu Baden Baden. Z. M., vol. xvii, p. 486). Green-red blind persons assort correctly with fuchsine glasses. The visual field for red is generally increased by a fuchsine glass.

MARTY, on the question of the *Historical Development of the Color-sense* (Vienna, 1879), says:—

"Man is said to have had a sensation of color at all times; but lower classes of animals may gradually have gained the faculty of qualitative perception of light, and then transmitted it to succeeding generations. But to man, a gradual development of his judgment of colors, and an alteration of his sensation of colors, are accorded.

NETOLICZKA, in his "*Researches on Color Blindness and Myopia*," (28 Jahresber, d. Steir-

mark, Laudes-Oberrealschule über das Studienjahr, 1878-79, Graz, 1879), says:—

"Holmgren's test is said to be the best. Among 1024 boys, 41 were color blind (completely and incompletely); in 31 the color-sense was reduced; 71 were not trained, that is, they sorted correctly, but only after some hesitation. The 283 girls had all a normal color-sense. The division into red-green and violet blindness is preferred. In 15 color-blind boys, Delbœuf's fuchsine stained glasses were employed, without, however, correcting the color blindness.

In PFLUGER's remarks upon *Methods of Examination for Color Blindness* (*Vortrag auf der IV, Vers. d. Arzth. Centralvereins u. d. Soc. Méd. de la Suisse, Correspondenzbl. f. Schweizer Aerzte*, Vol. ix), he says:—

Stilling's plates are entirely unreliable; also Cohn's embroidered plates. Daase's plates make rather high demands on the intelligence of the patient. Maxwell's disc is very desirable for the accurate study of a single case of color blindness, but it takes too much time for the examination of numerous persons. The polariscope can be recommended, but the instrument is too expensive. Holmgren's test and Pflüger's crape contrast method are best adapted for the examination of greater numbers. The methods in which spectral colors are used are especially suited to control examinations.

STEIN gives some interesting notes about the Nubians (*Frankfurter Zeitung*, No. 213). They distinguish the ground colors, like the European, but they have no accurate and well trained color-sense, and an uncertain nomenclature. The acuteness of vision is more than double.

SWANZY says (*Brit. Med. Assoc.*, Cork, Aug. 5-8, 1879; *Brit. Med. Jour.*, Oct. 4) that among 1230 males, 82, = 6.6 per cent., were color blind; among 90 females, not any. Holmgren's method was used. Nomenclature. (*Berl. Ges. f. Anthropol.*, March 15, 1879. *Zeitcher f. Ethnologie*, 1879, Sept. 3, p. 146.)

VIRCHOW finds the color-sense well developed in the Laplanders, but they have a deficient nomenclature.

From Vol. ix, No. 4, of the *A. f. O.*, we note the following, by Dr. C. A. LAMBERT, of Goshen, Indiana, on "*The Treatment of Ophthalmia Purulenta Gonorrhœica, etc.*"—

"I can only offer as a commentary on the present general plan of treatment, whether the end sought is abortive or curative, to say, throw scarification, leeching and iced compresses to the four winds; they destroy five eyes where they save one. The trouble can be effectually aborted and cut short at pleasure, thus producing a speedy convalescence and cure. I look upon these terrible disorders with as much complacency as I do on a simple case of acute catarrhal ophthalmia. (Italics our own.) The principal points in this treatment, as outlined in the

literature of the subject, I adhere to, such as maintaining the most scrupulous attention to cleanliness of cornea and ocular and palpebral conjunctiva, regulating the diet and habits of the patient, with perfect rest and repose of mind and body. The prescription I have learned to rely upon as almost a specific to the virus is as follows:—

|                     |           |
|---------------------|-----------|
| R. Morphine sulph., | gr. iij-v |
| Zinci chloridi,     | gr. ij-vj |
| Aquæ rosæ,          | gtt. x    |
| Aquæ dest.,         | ℥ j. M.   |

In the case of ophthalmia neonatorum the remedy should be much weaker. I might incidentally remark that I have found this combination of equal importance in gonorrhœal urethritis, without the internal administration of any remedies whatever, excepting in the case of general debility. In many cases there was no discharge after the first injection. Patients tolerate this injection as they would so much water."

We would consider it criminal negligence "if we looked complacently upon" either a case of blennorrhœa of the new-born, or gonorrhœal ophthalmia in the adult. Statistics go to prove that these sort of cases form a large majority of the whole number of eyes annually lost. Our advice to all those who have had but a limited experience in the treatment of leucorrhœal or gonorrhœal ophthalmia, is to regard such inflammations as most threatening from the onset. *There is no specific treatment* for such. Save the eye, and protect its fellow from inoculation by all the laws of hygiene and surgery you can couple with your common sense and experience, just as in the treatment of similar vaginal or urethral inflammations. Eyes are lost by necrosis of the corneal tissue, which breaks down, for want of vitality, because of the strangulating swelling of the palpebral and ocular conjunctiva. What is still presented and recommended by many of the eminent teachers in our medical schools, especially by the very men who decry specialists? "*Drop into the eye astringent solutions of varying strengths of nitrate of silver, sulphate of zinc, etc.*" Do not do it. You are acting the part of a coward. Hitting the poor eye when it is down. Take the advice of those experienced, and you will save eyes. We repeat, for the sake of emphasis, what Dr. Lambert says truly (*note the cause of his success*), "maintain the most scrupulous attention to cleanliness of cornea and ocular and palpebral conjunctiva, regulate the diet and habits of the patient, with perfect rest and repose of mind and body." We add, regulate your assistants, and nurses as well. They must expect no rest, or repose of mind or body. Eternal vigilance until the acute inflammatory stage be passed! Ice, and nothing but ice, will

allay the intense inflammation, and it must be withdrawn just so soon as the inflammation commences to subside. Herein lies the secret of the successful use of ice. Never put strong astringent collyria into the patient's or nurse's hands for use. Use them yourself, once or twice daily, *everting the eyelids and making the applications to the palpebral conjunctiva only*, being careful to wash them off before the everted lids escape. Alum, sulphate or sulpho carbolate, or *chloride of zinc*,\* may be used as weak washes, but not during the acute stage. We prefer the pure muriate to the sulphate of morphia and solutions of alum. Long naps are not desirable, either in the case of children or adults, as a good night's rest has cost many an eye. Eternal vigilance, to constantly cleanse the parts, is the watchword! Assist nature in every way, and do not "look complacently upon these terrible disorders" which contribute so largely to the blind in our asylums. We cannot do our whole duty, while mentioning this favorite subject, without referring those interested to a recent paper entitled "*Acute Suppurative Inflammations of the Eye*," by Dr. S. C. AYRES,† of Cincinnati.

From Dr. S. M. BURNETT's next "Quarterly Abstract (A. J. O., Vol. XI, No. 4) we call attention to a paper on the interesting subject of

*Cross-eye; its Origin, Prevention and Treatment.* By JOHN GREEN. *St. Louis Medical and Surgical Journal*, August 5th. G. points out the cause of convergent squint to be a disturbance of the normal relation between accommodation and convergence, and suggests as an important therapeutic measure, particularly in the early stages, a paralysis of the accommodation by a mydriatic, the paralysis to be continued for months if necessary—the accommodation being supplied by means of convex glasses. He reports important results from the method in his practice.

*A Case of Marked Intoxication, with Delirium, from the Use of Duboisin.* By C. J. LUNDY. *Michigan Medical News*, August 10th. The quantity of the drug used (by instillation) could not have exceeded  $\frac{1}{16}$  of a grain.

*On Affections of the Eye Consequent upon Whooping Cough.* By Dr. M. LANDESBURG. *MEDICAL AND SURGICAL REPORTER*, Sept. 18th, 1880. Four cases in all. In Case 1 there was serous infiltration of the retina, right eye somewhat swollen, macula lutea red, arteries thin, veins engorged. The two upper arterial

\* We have used the solution as recommended by Dr. L. of zinc chlorid, in two cases of gonorrhoeal ophthalmia, and have found it most grateful to our patients, and no doubt a most valuable application, and as an astringent wash, after the acute stage has passed, to be particularly recommended. The same solution, as an injection, at the same time, cured the urethritis in each case.

† The Cincinnati *Lancet and Clinic*, Feb. 12th, 1881.

branches were found to be permanently obliterated, and V. was reduced to  $\frac{1}{3}$ . In Case 2 there was complete exophthalmos of the right ball. In Case 3 there was ecchymosis in the retina. In Case 4 there was a subluxation of the lens in R. E.

*A New Mydriatic.* By H. S. SCHELL. *Philadelphia Medical Times*, October 6th. Schell has made eleven experiments with the homatropin hydrobromate, and deduces the following conclusions: Homatropin hydrobromate is not well adapted to the treatment of inflammatory or traumatic affections of the eye, on account of the conjunctival irritation it produces. It is especially adapted to the production of that temporary dilatation of the pupil and paralysis of the ciliary muscle which is so often required in examining the condition of refraction. The best solution to use is one containing 16 grains to 1 fl.  $\bar{z}$  aq. From 1 to 5 drops of such a solution may be required to produce the desired effect, according to the strength and activity of the ciliary muscle. Under the influence of a full dose the pupil attains its maximum dilatation in about twenty minutes. With a full dose the accommodation begins to fail in about ten minutes, and is usually totally suppressed in half an hour, although exceptional cases may require an hour. The total suppression lasts about three hours; the accommodation then gradually recovers itself, and is fully in action again at the end of ten or thirty hours from the time of last instillation. The local action of the mydriatic is not accompanied by any unpleasant effects upon the general system.

*A Case of Basedow's Disease (Exophthalmic Goitre), Terminating in Total Loss of Sight from Inflammation of the Cornea.* Dr. H. G. CORNWELL. *American Journal Medical Science*, October.

The cause of this rare result of Basedow's disease C. thinks is due, 1, to exposure of the eyeballs to the air, and wholly disassociated from any affection of the fifth pair or ganglion of Gasser; 2, to the affection of the tropic nerves alone, rendering the eye unable to resist the injurious influences of the air, dust, etc.

*Reflex Aphasia from a Glaucomatous Bulbus.* By A. WAXSTALL. *Trans. Am. Homœop. Oph. and Otol. Soc.*, 1880.

This is an interesting case to the neuropathologist as well as the oculist. From the clinical history, which is given in detail, it appears that a marked aphasia, which was the concomitant of an eye trouble in which there was + tension (whether primary or secondary is not clear), was thoroughly dispelled after an enucleation of the ball.

(To be continued.)

—A verdict was recently rendered in the District Court of Erie, Pennsylvania, against Dr. A. S. Lovett, in a suit for malpractice, for \$2450. The trial lasted two weeks, and the jury remained out twenty-four hours.

## CORRESPONDENCE.

## Danger of Dusting Calomel into the Eye.

ED. MED. AND SURG. REPORTER:—

I see, by the London *Lancet*, for February, 1881, that Dr. Henry Faulds, of the Tokio Hospital, claims to have made a discovery in the treatment of pterygium by the daily dusting of calomel dust into the eye.

The Doctor is not correct in having anything new in the treatment, although it is not generally laid down in the text-books upon eye disease, for I have dusted calomel into the eyes, not only for pterygium, but for granular lids, when there was little or no purulent discharge. And when a patient comes to me with a foreign substance in the eye I never allow them to leave the office until I have dusted some calomel into the affected eye, and such has been my practice for the last six years, with the most flattering success.

I find that the daily dusting is rather too much of an irritant, and that cases do better to only dust the eye every other, or even skip two days between the dustings. I have a patient who had very severe chronic granular ophthalmia, with a cloudy cornea, who has used the calomel for more than a year with no injurious effects whatever; still, I think that all practitioners who dust calomel into the eye should heed the suggestions of Dr. Schläefke:—

1st. Where a patient is taking iodide of potassium internally, the local application of calomel to the eye excites an acute inflammation.

2d. Iodide of potassium when taken internally is rapidly disseminated through the organism. It appears in the secretions, where its presence can be detected in a few minutes.

3d. When the iodide is given in doses of six grains twice daily it is always found in considerable quantities in the tears.

4th. Although calomel is only very slightly soluble in water, it is ten times more soluble in a solution containing seventy-five per cent. of the chloride of sodium.

5th. When dusted on the conjunctiva calomel is rapidly dissolved, and exercises a chemical action.

6th. If it is thus employed while the patient is taking the iodide of potassium, the iodide and biniodide of mercury are formed in the tears, and these caustic substances cause inflammation.

Thus care should be exercised, especially in old syphilitic subjects, who are liable to take iodide of potassium at any time.

Hoping that some one may profit by these suggestions, as I have done, I send them to your valuable journal.

E. W. HILL, M.D.

Glens Falls, N. Y., March 24th, 1881.

## Large Amount of Opium to a Child.

ED. MED. AND SURG. REPORTER:—

About noon, 28th ult., a man came to my office in breathless haste, asking me to go to his house, distant about five miles, saying, "the baby had the stomach-ache this morning; my wife gave it some laudanum and cannot waken

it." On my arrival I found a babe (eight months old that day) lying in the arms of its almost frantic mother, pale, comatose, bathed in perspiration, extremities cold, slow, feeble pulse, and pupils contracted to the size of a very small pin-head. Noise, rough handling, and dashing cold water in its face utterly failed to arouse the child. I was told the child cried hard that morning, hindering the mother from doing her work, and she gave her a dose of laudanum about 5 o'clock, and another about two hours later. It was then 1 P.M. I asked how much she gave, and she said she did not know. "Surely," said I, "you know whether it was four, six, or ten drops." "But, Doctor, I did not drop it." Finally she told me the first dose was half a teaspoonful, and the last one all the teaspoon would hold. I carefully measured the teaspoon, and it held two drachms. On my expressing surprise that it had not killed the child outright, she said she had often given it half a teaspoonful. Her husband brought from the pantry a three-ounce vial, containing less than one ounce of laudanum, and informed me that that was the fifth vial of laudanum of that size which had been given to the child; making fourteen ounces of laudanum administered to a child during the first eight months of its life. To resuscitate the child seemed a hopeless task. I gave five drops fluid extract of belladonna and a teaspoonful of whisky, in a little water, which with difficulty was swallowed. I then vigorously spanked the child, at first with my hand and afterward with a ruler, until the buttocks were intensely reddened, before I could arouse it sufficiently to emit a cry. I worked at it in this way, at intervals, for more than two hours; kept it awake by noise, dashing cold water in the face, and shaking it, but when these means failed and it sank into a deep sleep, I had recourse to the ruler. The next day the child appeared well, excepting being somewhat dumpish. Instead of the child being constipated by such enormous doses of laudanum, it has always been troubled with diarrhoea. I will only add that the laudanum was all purchased at a first-class apothecary store, and was a reliable article.

T. C. WALLACE, M.D.

Cambridge, N. Y., April 4th, 1881.

## London International Medical and Sanitary Exhibition

ED. MED. AND SURG. REPORTER:—

SIR—We have much pleasure in announcing that arrangements have been completed for holding the International Medical and Sanitary Exhibition initiated by the Executive Committee of the Parkes Museum of Hygiene.

This Exhibition will be held on the occasion of the Meeting of the International Medical Congress of 1881, and will be open from July 16 to August 13.

The Exhibition will comprise everything that is of service for the *Prevention, Detection, Cure and Alleviation of Disease*, and will be divided into three sections.

*Medical Section.*—Surgical Instruments and Apparatus; Appliances of the Ward and Sick-



room; Drugs, Disinfectants, Medical Dietetic Articles and Mineral Waters; Electrical Instruments and Appliances; Microscopes and Optical Apparatus; Apparatus of other kinds used in the Investigation of Disease; Appliances used for the treatment of Sick and Wounded during War; Street Ambulances, etc.; Appliances used in Teaching Medicine; Books, Diagrams, Models, etc.

*Sanitary Section.*—Domestic and Hospital Architecture; Planning, Construction, Decorative Materials; Ventilation, Lighting, and Warming; Water Closets, Sinks, Baths, etc.; Sewerage and Drainage; Water Supply and Filtration; Health Resorts and Sanitaria; Books, Diagrams, Models, etc.

*Miscellaneous Section.*—Applications of hygienic principles to Food and Dietaries, Clothing, etc.; School Furniture and other articles more or less connected with the general purpose of the Exhibition.

The Exhibition will be held at South Kensington, space having been granted for it by the Royal Commissioners for the Exhibition of 1881. Applications for space from Great Britain and Ireland, and the Continent of Europe, must be made not later than Thursday, March 31, 1881; but applications from India, the Colonies, and America, will be received up to April 16, 1881.

Certificates of Merit will be awarded to Exhibitors. New inventions exhibited will be protected under a certificate from the Board of Trade. Exhibitors will be charged for space, and it is hoped that the Exhibition, in this and other ways, will be made to pay its expenses. An undertaking of this magnitude, however, is not without risk, and although upward of £800 have been subscribed as a Guarantee Fund, we hope the committee will receive such additional contributions as will enable them to thoroughly carry out their work. A list of the guarantors will be published in the catalogue.

Forms of applications for space, and all particulars, may be had of the Secretary of the Exhibition Committee, *Parke's Museum of Hygiene, University College, London.* Office hours, 10 to 4; Saturdays, 10 to 2.

We are, Yours, etc.,

JOHN ERIC ERICHSEN, F.R.S.,  
(President of the Royal College of Surgeons),  
Chairman of the Exhibition Committee.

MARK H. JUDGE,  
(Curator of the Parke's Museum of Hygiene),  
Secretary of the Exhibition Committee.

*Parke's Museum of Hygiene, University College,  
Gower Street, Feb. 22, 1881.*

## NEWS AND MISCELLANY.

### An Anatomical Act in Michigan.

Our Michigan exchanges give us the new Anatomy Act of that State, which has recently become law. Under its provisions the Demonstrator of Anatomy in the University of Michigan, at Ann Arbor, is made receiver and distributor of the cadavers from the prisons and poorhouses of the State. Unless the body is claimed within

thirty-six hours after its decease the keeper of prison or poorhouse shall ship it to the University dissecting rooms, where it shall be properly "embalmed or put in a state of preservation," and be still subject to the claim, on the payment of expenses incurred, of relatives or legal representatives for ten more days. At the expiration of this time bodies thus received "shall be used for the advancement of anatomical science in the State and in the following institutions of learning only, viz: The University of Michigan, the Detroit Medical College and the Michigan College of Medicine. And the said bodies shall be distributed to and among the same equitably, and in the order in which they are received, and the number assigned to each by said demonstrator of anatomy shall be proportional to that of its students in actual attendance. And each of said institutions shall pay quarterly to said demonstrator its ratable proportion of the expenses borne and incurred under this act."

The expenses incurred will consist of a sum not to exceed fifteen dollars, which the demonstrator shall pay the keeper of the poorhouse or prison for each body received, to cover the expense of boxing and shipping, and the cost of "embalming or putting in a state of preservation."

The Act apparently gives satisfaction to the parties most interested.

### Motion and Rest.

At a recent lecture at the Franklin Institute of this city by Mr. D. S. Holman, he instanced charcoal as a full and apparently inert substance, but when it is powdered, mixed with water and placed under a microscope of a thousand diameters, by which each particle or atom is magnified one million times, we can see the vibratory motion of the atoms. This is equally true of every substance which we can reduce to powder and suspend in clear water, and this motion of atoms is continuous and perpetual. He undertook to show that these particles were absolutely running in a piece of iron, or in corundum, the hardest substance known, after the diamond.

Motion is always indicated by temperature, and when it becomes sufficiently rapid, the atoms fly apart, and the matter becomes liquid and then gaseous. The term solid is a misnomer, for, in fact, a mass of cast-iron is nothing more than a mass of jelly—and this never ceasing motion is an absolute property of not living matter—and there is no such thing in the universe as absolute rest.

### Examination for the U. S. Marine Hospital Service.

A competitive examination will be held in Philadelphia, to fill three vacancies in the position of Assistant Surgeon in the U. S. Marine Hospital Service, on April 25th. Candidates must be between 21 and 30 years of age, and graduates of a regular medical college.

Medical gentlemen desiring to apply for examination should make their application to "Supervising Surgeon-General, U. S. M. H. S., Washington, D. C.," without delay.

## How "Free" Quinine Works.

We clip the following extract from the *North Carolina Medical Journal*, and recommend it to the consideration of an editor in the State immediately west of North Carolina:—

"We have been favored with the Annual Review of the Drug Trade of New York, for the year 1880, by D. C. Robbins, Esq.

"It is shown in the review of the importations and value of cinchona barks for 1880, that they were of inferior quality.

"It is remarkable, also, that the price of quinine to the consumer has increased since the duty on it has been removed. We believed, at the time the American Medical Association was so zealous in bringing about the abolition of import duty, at Atlanta, that it was a hasty and ill-advised step, and we voted against it.

"As the matter now stands, Congress can do no less than remedy the mistake by removing the tax and duty on material concerned in the manufacture of quinine."

## The Promises of the Sick.

In a case tried at Paris, where a surgeon claimed 6900f. for thirty-one dressings of a wound and for accessory expenses, the Court ruled that "there could be no valid agreement between the patient and his doctor, for the former, struggling for his life, is no longer master of his will, and if he makes any agreement it is only fear and necessity that guide his will.

## Personal.

—Dr. Charles K. Mills has been appointed Lecturer on Mental Diseases in the Medical Department of the University of Pennsylvania.

## Items.

—The Cleveland Medical College and the Medical Department of the University of Wooster, located at Cleveland, are about to be united into one Medical College. Hon. H. B. Hurlbut has given \$20,000 on condition that this be done, and the authorities of both colleges have decided to unite.

—Rev. T. B. Miller, who sprang into public notoriety some time ago, through his connection, as "Dean," with the Philadelphia College of Medicine and Surgery, a bogus institution located on Tenth street near Race, and Dr. Isaac J. Hathaway, of this city, were arrested, April 5th, on the charge of criminal malpractice on a young woman, and were bound over for trial.

—M. Menier, the famous proprietor of the "Chocolat Menier," recently died in Paris, at the age of fifty-five years. He was at one time the leading wholesale druggist of Paris, and he had one of the finest private laboratories in the world. For years he had spent large sums in endeavoring to discover a practical method for the synthetic production of quinine and morphine.

—A meeting in aid of the fund to supply raised letter books for the blind was held in Boston,

April 1st, and considerable money was subscribed. The intention is to raise a permanent fund of \$75,000. Miss Laura Bridgman, the celebrated deaf, dumb and blind girl, was present at the meeting, and read from one of the prepared books of the Scripture, the passages being traced by her with the fingers of one hand and communicated by the fingers of the other to an interpreter who spoke them to the audience.

## OBITUARY NOTICES.

—Dr. William H. Phibbs, surgeon of the Inman steamship City of Richmond, died in New York, on April 3d. Dr. Phibbs was thirty-four years of age, and for a number years had been in the employ of the Inman Line, and had borne a high reputation.

—Dr. Josiah Hornblower, a well-known and highly respected physician of Jersey City, died April 3d, at his residence, at the age of 71 years.

## QUERIES AND REPLIES.

## Tripolith.

*Dr. Sanford, N. Y.*—Tripolith is a secret preparation manufactured by a firm in Switzerland, principally for stucco work and other uses to which plaster of Paris is put. It has been adopted for surgical splints and jackets by various German surgeons.

*Dr. W. H. K., of Ohio*, asks how may a solution of atropia for hypodermic purposes be kept for some length of time without becoming unfit for use.

*Ans.*—Prof. Gubler (*Therapeutics*, pp. 176-8) discusses the injury to hypodermic solutions arising from keeping, and traces them to either crystallization or the development of algæ. The latter can be prevented by the addition of one of the anti-zytomyces; the former only by re-dissolving.

*Dr. S. J. R., of Pa.*—We mention Liddell, on Apoplexy, \$4.00; Erichsen, on Concussion of the Spine, \$2.25; Charcot, Localization of Brain Disease, \$1.50; as possibly what might suit you.

*Dr. C. C. S., of Ala.*—The abuses of medical charity have been discussed in various medical journals, but we know of no separate publications on the subject. Should our subscribers know of any, they will confer a favor by sending in the titles.

## MARRIAGES.

SIMSOHN—STERN.—On April 6th, by the Rev. Dr. S. Hirsch, Jos. S. Simsohn, M.D., and Miss Clara, daughter of Mr. Morris Stern, all of Philadelphia.

STEIN—KAUFMAN.—On Saturday, April 9th, at the residence of the bride, by the Rev. Dr. Eccleston, Gottlieb Stein, M.D., and Catharine Kaufman, daughter of the late William Kaufman, all of Stapleton, Staten Island, New York.

## DEATHS.

GAINES.—At Boonton, N. J. March 31st, Dr. E. B. Gaines, in the 90th year of his age.

HORNBLOWER.—Jersey City Heights, April 3d, Dr. Wm. Hornblower, aged 71 years.

MORRIS.—On March 29th, 1881, at Norristown, Pa., in his 74th year, Dr. Sidney R. Morris, formerly of this city.